Maternal and Child Health Services
Title V Block Grant

State Narrative for New Jersey MCH Block Grant

Application for 2013
Due July 2012

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I. General Requirements

Accorded to the Maternal Child Health Bureau guidance for completing the MCH Block Grant Application and Annual Report, all of the previous year's narrative has been left in place up to sections IV C & D (National & State Performance Measures). Changes of any kind (additions, corrections, updates, and revisions) begin at the left margin of each paragraph or section where the change applies with the symbol **/2013/** and end with **//2013//**. In this manner, entire sections will not have to be rewritten and all changes will be easy for all readers of the application to find.

Beginning with Sections IV C & D (National & State Performance Measures), updates have been made to last year's narrative as concisely as possible.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "Guidance And Forms For The Title V Application/Annual Report," Omb No: 0915-0172; expires January 31, 2015.

E. Public Input

To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing is scheduled annually in May. A draft of the application narrative is posted on the Department's website four weeks prior to the public hearing. Notice of the public hearing is published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application is posted on the Department's website and is mailed to over 300 individuals on the Division of Family Health Services mailing and e-mail lists.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E

II. Needs Assessment

In application year 2013, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

The Maternal and Child Health Block Grant Application and Annual Report, submitted annually by all states to the Maternal Child Health Bureau (MCHB), provides a overview of State initiatives, State-supported programs, and other State-based responses designed to address their maternal and child health (MCH) needs. The Division of Family Health Services (FHS) in the New Jersey Department of Health and Senior Services (NJDHSS), Public Health Services Branch posts a draft of the MCH Block Grant application and annual report narrative to its website each year in the second quarter of each calendar year to receive feedback from the maternal and child health community.

A brief overview of New Jersey demographics is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state in the nation with 8.7 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

New Jersey is one of the most racially and ethnically diverse states in the country. According to the 2010 New Jersey Population Estimates, 68.6% of the population was white, 13.7% was black, 8.3% was Asian, 0.3% was American Indian and Alaska Native, and 2.7% reported two or more races. In terms of ethnicity, 17.7% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2010, 26.9% of mothers delivering infants in New Jersey were Hispanic, 45.5% were white non-Hispanic, 15.2% were black non-Hispanic, and 10.3% were Asian or Pacific Islanders non-Hispanic. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDHSS. The Division of FHS, the Title V agency in New Jersey, has identified 1) improving access to health services, 2) reducing disparities in health outcomes and 3) increasing cultural competency of services as three priority goals for the MCH population. Specific attention has been placed on improving birth outcomes, obesity prevention, early access to prenatal care, black infant mortality reduction, reduction of risk taking behaviors among adolescents, newborn biochemical screening, autism, and improving access to quality care for children and youth with special health care needs (CYSHCN). These goals are consistent with the Life Course Perspective which proposes that an inter-related web of social, economic, environmental, and physiological factors contribute in varying degrees through the course of a person’s life and across generations, to good health and well-being.

Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. Title V will continue to maintain a safety net of direct services, especially for children with special health care needs. During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

To improve New Jersey’s commitment to early prenatal care and healthy births, a Commissioner’s Prenatal Care Task Force Report in 2008 issued recommendations to increase public awareness of preconception health; ensure the availability of ongoing early prenatal care services for women in areas affected by hospital closures or reduction in obstetric services; and promote equity in birth outcomes. Following the recommendations from the Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Goals of the Access to Prenatal Care Initiative are to increase public awareness of preconception health; ensure the availability of ongoing early prenatal care services for women in areas affected by hospital closures or reduction in obstetric services; and promote equity in birth outcomes. Projects seeking funding needed to

demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care. Nine projects were funded within the Access to Prenatal Care Initiative representing a variety of best practice models.

To improve access to health services, the State has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs) since 1992. In SFY 2012, reimbursement for uninsured care remained at $46.4 million.

An emerging MCH issue in NJ and nationally has been the growing obesity epidemic. In May 2008 the NJDHSS was awarded a 5 year cooperative agreement by the Centers for Disease Control and Prevention (CDC) to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement ONF has taken the lead in building a robust infrastructure by creating a statewide partnership of organizations and individuals, called ShapingNJ, to collaborate, build capacity and develop a comprehensive and coordinated system to halt further increases in obesity and other chronic diseases.

CDC recognizes six target behaviors for intervention to prevent or control obesity including: 1) increase breast feeding initiation, duration and exclusivity; 2) increase physical activity; 3) increase fruit and vegetable consumption; 4) decrease TV viewing; 5) decrease the consumption of sugar sweetened beverages; and 6) reduce consumption of high energy dense foods. Additionally, CDC recommends five settings for the prevention and treatment of obesity including medical/ healthcare, community, schools, childcare and the worksite. CDC requires that strategies are targeted to populations that are at risk for health disparities as indicated by data.

Priorities for the NPAO State Plan include to: 1) increase number, reach, and quality of targeted policies and standards to support a healthy lifestyle; 2) increase access to and use of environments that support healthful eating and physical activity; 3) increase the number, reach and quality of social and behavioral approaches that complement policy and environmental strategies; 4) identify data sources and monitor outcomes; 5) engage strategic public/private partnerships at the state & local level; and, 6) prioritize use of evidence-based strategies/best available evidence.

Federal American Recovery and Reinvestment Act funding for New Jersey has focused on three NPAO components including: 1) promote the initiation and duration of exclusive breastfeeding among NJ mothers; 2) improve nutrition, physical activity and decrease TV viewing for children in licensed child care centers and registered family day care homes; and 3) build capacity among local health departments to implement policy and environmental change at the community level to impact obesity.

Additionally, a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco. Three grants, each located in one of three New Jersey regions (North, Central and South), have been awarded funds to be used for the implementation of CDC's model in at least eight public middle- and/or high- schools of public school districts.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. All newborns receive mandated screening for 54 disorders. New Jersey is among the top 5-10 states in offering the most screenings for newborns. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure the baby has immediate access to confirmatory testing and treatment. In Fiscal Year 2011, significant improvements in laboratory testing were made to decrease false positive results; 102,315 newborns received initial screens and 5,590 infants had abnormal results.

The Program meets and communicates regularly with several advisory panels composed of parents, physicians, specialists and others to ensure New Jersey's program is state-of the-art in terms of

screening technologies, operations and is responsive to any current concerns regarding newborn screening.

According to the Centers for Disease Control and Prevention's (CDC) 2008 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 30, 2012, one of every 49 eight year olds in Union County, New Jersey had autism. Thus New Jersey continues to have one of the highest rates of autism in the United States.

The State's proposed rule for the implementation of the Autism Registry was formally adopted in September 2009. The registry includes a record of all reported cases of autism with other information deemed relevant and appropriate to (a) improve current knowledge and understanding of autism, (b) conduct thorough and complete epidemiologic surveys of autism, (c) enable analysis of this problem and (d) plan for and provide services to children with autism and their families. Reporting to the Autism Registry is done through the existing process of reporting to the Birth Defects Registry. To accommodate Autism, the BDR was expanded and is now available as the web-based Birth Defects & Autism Reporting System.

The Governor's Council for Medical Research and Treatment of Autism (the Council) has been transferred to the Office of the Commissioner at NJDHSS. The Governor's Council for Medical Research and Treatment of Autism is a 14 member, legislatively mandated Council that is charged with creating a Center of Excellence for Autism in the State where basic science and clinical research studies, as well as clinical diagnosis and treatment initiatives can take place. The Council currently has two major grant initiatives (a $5 million dollar Biomedical Research Grant program and an $8.55 million dollar Clinical Enhancement Center Grant program). The Clinical Enhancement Center Grant Program will end in June 2011; a new request for applications is currently being developed.

The Department released the Early Identification of Autism Spectrum Disorders: Guidelines for Healthcare Professionals in New Jersey in April 2009. These guidelines have been disseminated to health care professionals and members of the public to assist in evaluating infants and toddlers living in the State for autism, to ensure timely referral to appropriate services, and to provide information on the medical care of individuals with autism.

Maintaining ongoing Title V supports and services for children and youth with special health care needs (CYSHCN) and improving access to quality care for NJ CYSHCN is enhanced by collaboration with community partners. To that end, Special Child Health and Early Intervention Services (SCHEIS) will work with the Statewide Parent Advocacy Network (SPAN), the NJ Academy of Pediatrics, Pediatric Council on Research and Education (PCORE), Special Child Health Services (SCHS) Case Management Units (CMUs), pediatric specialty providers and other community-based organizations on SPAN's HRSA funded State Implementation Grant for Integrated Community Systems (Integrated Systems Grant or ISG 1). The ISG 1 is providing resources and manpower to address capacity in the identification of need, coordination of care and access to information across multiple systems, data sharing, collaborating with community partners and evaluating success. In addition, NJ has been very successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; Child Evaluation Centers including the Fetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP (Wisdom, Resources and Parent to Parent). With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM, monitoring of services offered and/or provided to determine client outcomes. Information garnered from both the ISG 1 and CDC Surveillance initiatives is anticipated to support and enhance NJ's efforts to achieve the six core MCHB outcomes for CYSHCN.

Title V CYSHCN shares an active collaborative partnership with SPAN and AAP, New Jersey Chapter, which was featured at two "Knowledge Café" sessions at this year's Association of Maternal and Child Health Program's annual conference. Title V CYSHCN, SPAN, and AAP communicate regularly via monthly scheduled conference calls in addition to meetings and other activities to strengthen this relationship. Title V, SPAN, and AAP, as well as over 100 other local, county, and state organizations

and diverse family leaders also all share in a partnership working together to better serve children and families with special health care needs. This partnership and its accomplishments was recognized at the Community of Care Consortium Statewide Summit in April 2012.

On July 1, 2009, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). This new electronic reporting system updated and replaced the Birth Defects, Autism, and Special Needs Registry, which has been an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly is a mechanism to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based BDR of children with all defects. Starting in 2003, the SCHS Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition. The BDARS, at present, refers all living children and their families to our SCHS Case Management Units, but does not monitor the progression into the service stream. On July 1, 2009, the first case was entered into the new web-based BDARS. EIM staff spent most of the second half of 2009 training reporting facilities on the use of the new BDARS. In 2010, over 9,700 children were newly registered with the BDARS.

New Jersey has been very successful in linking children registered with the BDARS (formerly known as the Special Child Health Services Registry) with services offered through our county based Special Child Health Services Case Management Units (SCHS CMUs). However, the System did not further track children and families to determine if and what services were offered to any of the registered children. To address this weakness, a second module is being added to the Birth Defects and Autism Reporting System (BDARS). This module will be used by the SCHS CMUs to track and monitor services provided to the children and their families. It will electronically notify a CMU when a child living within their jurisdiction has been registered. Also included in the module is the ability to create and modify an Individualized Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

The Case Management module went online in August 2011 in one county. Mercer County had volunteered to be the early adopter in order to test the functionality of the system in a live environment. The module was successfully adopted by all 21 counties by January 2012.

In fall 2009, the New Jersey Early Hearing Detection and Intervention Program (EHDI) began a new collaboration with several Federally Qualified Health Centers (FQHCs), with supplemental grant funding received from the Health Resources and Services Administration (HRSA). Three FQHCs were selected for funding that would allow them to purchase equipment and train staff to allow them to conduct outpatient rescreening for infants who did not pass their initial screening. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up. Three FQHC's purchased hearing screening equipment in 2010 and were trained on screening infants. In early 2011, two additionally FQHCs were awarded funding to purchase screening equipment. Once the equipment is delivered, the EHDI audiologist will train the FQHC staff on proper screening techniques.

Another collaboration made possible by the supplemental HRSA funding was the implementation of follow-up phone calls to parents and physicians of children in need of follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up after discharge, the level of effort put into this by each hospital varies widely. Thus this program provides supplemental contacts to compliment the hospital's outreach efforts. This outreach is being done through funding provided to the Mercer County Case Management Unit. In 2010, over 1,700 families were contacted through this initiative. This project will continue in 2012.

The NJ Pediatric Hearing Healthcare Directory was updated in 2010. Annually, audiologists and hearing aid dispensers in NJ are asked to verify their current listing and new facilities are added. The 2010 update included a new section listing pediatric otolaryngologists, made possible with the partnership of the New Jersey Hearing Evaluation Council. There were 33 pediatric otolaryngologist offices who wished to be included in the Directory. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services. In April 2011, the NJ Pediatric Hearing Health Care Directory was improved as a searchable on-line directory with the ability to map facility locations and obtain driving directions. This update was made possible through partnership with the DHSS Office of Information Technology Web Team.

Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Disease took effect on August 31, 2011. Since then, NJDHSS has developed a mechanism to collect data on all infants screened by having birthing facilities submit quarterly aggregate data reports. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry. In the first quarter of screening, at least two infants with previously unsuspected critical congenital heart disease were detected through the screening program. NJDHSS continues to provide technical assistance to the birthing facilities and is also working to develop educational materials for parents and health care providers**.**

The Birth Defects and Autism Reporting System (BDARS) was utilized to track all infants who failed their Pulse Oximetry screen. At present, a reporting template has been copied into a note field to capture relevant information. Currently a complete Pulse Oximetry Module is being programmed for use in the BDARS. This is anticipated to be implemented by June 2012.

The following MCH Block Grant Application/Annual Report provides a detailed overview of public health programs designed to address the MCH needs in New Jersey consistent with the MCH Bureau's growing recognition for the need to target upstream determinants of health and support for a Life Course Perspective. FHS is looking to address health risks earlier in the life span, during developmentally sensitive periods, when prevention, early intervention and health promotion can yield the greatest benefits.

B. Agency Capacity

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The MCHS and SCHEIS Programs ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in New Jersey originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.,); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program (Title 26:2-130-137); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following is a description of New Jersey's Title V capacity to provide preventive and primary care services for pregnant women, mothers and infants, preventive and primary care services for children, and services for CYSHCN.

III. B. 1. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. Prenatal care, family planning, perinatal risk reduction services for women and their partners, post partum depression, mortality review, child care, early childhood systems development, lead poisoning prevention, immunization, oral health, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children through the Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

/2012/ The Department has made the commitment to decrease the number of MCHC from 6 to 3 by the end of 2011. The MCHC have been directed to move forward with consolidation in an effort to

decrease costs to both the hospitals and the public sector. As of July 1, 2011 there are 5 consortia.//2012//

/2013/ The Department is committed to the reduction to 3 MCHC. Negotiations and due diligence in the northern area of the State are expected to result in consolidation by June 30, 2012; resulting in a total of 3 MCHC.//2013//

The Commissioner's Prenatal Care Task Force was convened by former Commissioner Heather Howard in February 2008 to improve access to early prenatal care and improve healthy birth outcomes. The Task Force's charge was to make recommendations to improve access to first trimester prenatal care in New Jersey and ultimately to increase the number of women seeking and receiving care within the first trimester of their pregnancy. One recommendation of the Task Force was to redirect current funding to an Access to Prenatal Care Initiative. Further information about the Access to Prenatal Care Initiative to increase improve access to early prenatal care and improve birth outcomes, is provided in the Section on National Performance Measure #18.

To promote healthy births, MCHS has embraced the Fetal Infant Mortality Review (FIMR) Program as a mechanism for quality improvement. FIMR is one of the original American College of Obstetricians and Gynecologists (ACOG) Partnership projects. The overall goal of New Jersey FIMR is to establish a statewide system of fetal-infant mortality review by implementing or expanding FIMR projects with each of the six MCH consortia. New Jersey follows guidelines for planning and implementing community fetal and infant mortality review developed by the National Fetal-Infant Mortality Review Program (NFIMR). The projects use standardized data collection, entry and reporting methods to ensure consistency of the review process throughout the State. This includes using data abstraction and case review summary forms developed by NFIMR and modified by New Jersey FIMR.

The major goals of the Perinatal Addictions Prevention Project (PAPP) include providing professional and public education, encouraging all prenatal providers to screen all of their pregnant patients for substance use/abuse and developing a network of available resources to aid pregnant substance using/abusing women. Risk-reduction coordinators working with this project provide ongoing regional professional training, individual on-site training, technical assistance and monitoring, grand rounds training, networking, and a link between regional and local services relating to prenatal substance use/abuse.

Multiple studies demonstrate the benefits to both mother and infant with use of screening, assessment, and referral. NJ has adopted the 4P's Plus, designed specifically for prenatal care settings, as the screening tool that will be used. Developed by Dr. Ira Chasnoff, the questions are broadly based, highly sensitive and require only 'yes' or 'no' response. When the provider asks just a few questions, it results in quick identification of patients in need of in-depth assessment or follow-up monitoring. The obstetric providers' participation in this screening project is voluntary. They screen pregnant women during their first prenatal visit and then again during their 28 week visit. The screening information is collected on a statewide basis.

/2013/ Approximately 30% of the pregnant women were screened for substance use during the past year. The majority of these patients were seen at public clinics. Referral information is given to those women who are smoking, using drugs and/or alcohol and those who have possible domestic violence issues. Last year there were 153 education programs held for over 2527 professionals. There were 425 programs held to educate the general public and approximately 23,429people participated.//2013//

/2012/ NJ successfully applied for the 2010 Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula Grant to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand New Jersey's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project will be carried out in collaboration with the

Department of Children and Families (DCF). Currently DCF provides funding and administrative oversight to 35 evidence-based home visitation (EBHV) programs in New Jersey.

A comprehensive needs assessment for home visiting services was submitted as part of the MEIC HV grant application. The needs assessment included: 1) identification of the at-risk municipalities where evidence-based home visiting (EBHV) services will be provided; 2) a detailed assessment of the particular needs of the identified municipalities in terms of risk factors, community strengths, and existing services; 3) identification of home visiting services to be implemented to meet identified needs in the identified municipalities; 4) a description of the State and local infrastructure available to support the program; 5) specification of any additional infrastructure support necessary to achieve program success; and 6) a plan for collecting benchmark data, conducting continuous quality improvement and performing required program evaluation.

NJ also applied for the 2011 MIEC HV Competitive and Formula Grants to further expand home visiting services. //2012//

/2013/ The notice of grant award was received for the competitive MIEC HV application. Discussions and negotiations with partners to implement the expansion project began in April 2012.//2013//

Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. NJDHSS offers a PPD helpline (1-800-328-3838) that operates 24 hours per day, seven days a week to provide resources and information to women and their families and friends. In addition, a dedicated Web site (www.njspeakup.gov) provides educational materials such as brochures, videos, books, support groups, FAQs, and other helpful Web sites on postpartum depression and other perinatal mood disorders.
/2012/ Funding for Post Partum Depression Education was used to support the PPD initiative via public service announcements and production of materials for community distribution was eliminated. The MCHC serve as a resource and continue to provide technical assistance via health service grants to the member hospitals and other health care providers/facilities in implementing the law.//2012//

/2013/ Due to the consolidation of the MCHC, a portion of the PPD funding has been redirected from infrastructure to direct client services beginning July 1, 2012 including developing mechanisms for follow up of women with positive screens.//2013//

/2012/ The elimination of $7.5 million of State dollars in July 2010 to the family planning delivery system required the RPHS Program to restructure the services to maximize the ability to locate at least one family planning clinical health care site in each of the 21 counties. In cooperation with the New Jersey Family Planning League, services are provided in each of the 21 counties.//2012//

/2013/ Family planning services continue to be provided in each of the 21 counties.//2013//

III. B. 2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCHS, focuses on primary prevention strategies. The emphasis in Child Health is to prevent lead poisoning among children under six years of age through the collaborative, prevention-oriented outreach and education of to parents, and property owners, and the education of health care providers.

The Childhood Lead Poisoning Prevention (CLPP) Project uses is a home visiting model to provide program providing case management and environmental interventions for children six years of age or younger with confirmed elevated blood lead levels. Twelve sites throughout the State receive funding to

assess blood lead levels, immunization status, nutritional status, growth and developmental milestones, and parental-child interaction, in addition to identifying and then provide education, supportive guidance, and assisting property owners in the remediation of lead hazards.

The goal of the CLPP Project is to promote a coordinated support system for lead-burdened children and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), Department of Children and Families, Department of Education, Department of Community Affairs, and community-based agencies that provide early childhood services. Services provided this year include a healthy homes assessment tool so that health and safety issues in the home can be identified and remediated so that homes are free of disease-causing agents and sources of preventable injuries. DHSS has established a partnership with Department of Human Services home visitation programs that provide services for pregnant women, infants, young children, in addition to resource family homes that provide a safe residential environment for children who are in the foster care system.

/2013/ A strategic plan is being developed to provide an outline to enhance and streamline home visitation services provided by State/local government and community-based organizations and to promote compliance and enforcement of protective State regulations and local ordinances. The project's goals, objectives and activities are integrated with New Jersey's federally-funded 2011 MIEC Home Visiting grant.//2013/

/2013/ In September 2011, the CLPP project was awarded funding to integrate a healthy homes approach into the current CLPP service delivery system. This included the integration of a healthy homes assessment tool so that health and safety issues in the home can be identified and remediated.//2013//

Adolescent Health funds through June 2010 the Community Partnership for Healthy Adolescents (CPHA) initiative that addresses injury and violence (including bullying and gangs), risk behavior reduction through positive youth development approaches, and school health. Beginning July 2010, the focus of Adolescent Health will be to expand and enhance the Department of Education's (DOE) cooperative agreement with the CDC to implement the CDC Coordinated School Health (CSH) model. Successful CSH applicants, selected through a competitive application process, will be responsible for the administrative oversight, training, technical assistance and resource support for the implementation of CSH in at least eight (8) middle- and/or high schools of public school districts geographically located one each, in three New Jersey regions: Northern, Central or Southern. School districts are a required partner for this application**.**

School Health (SH) Specialists, hired by the successful applicants will collaborate with a School Health (SH) Coordinator identified by the school district partner. The SH Coordinator will ensure the implementation of required school health activities and assure that the activities, funded by this grant, align with State goals and project objectives. As a result of participation, the school district partner is expected to progressively expand the implementation of CSH district-wide. Collaboratively, the DHSS with its three successful applicants and their school district partners will join the Department of Education's (DOE) New Jersey CSH Demonstration Project in serving as the proactive leaders to mobilize New Jersey's expansion of CSH statewide.

The goals for this pilot project are to increase the number of schools that are using CDC's CSH model to: 1) address the physical, emotional and social well-being of their students, 2) create opportunities for healthier choices by students and school staff through environmental or policy change strategies, and 3) strengthen and sustain state and school district capacity to support a coordinated school health system through effective leadership, strategic partnerships, youth engagement, funding development and the use of data-driven and best practices or evidence-based programs.
/2012/ Three regional grantees - the Center for Prevention and Counseling (North), Empower Somerset (central) and Atlanticare (south) - were approved for funding and on July 1, 2010 initiated activities for the implementation of CDC's CSH model. Three areas to be addressed on a statewide basis are: 1) sustainability; 2) youth involvement and 3) project recognition.

Workgroups are anticipated to be formed during the spring of 2011 and a goal statement and objective(s) identified by August 2011. DHSS/DOE CSH is a co-lead with Rutgers University for the implementation of school-based strategies developed by the CDC NPAO Shaping NJ Partnership to meet the CDC-approved State Plan objectives.//2012//

/2013/ The CAHS Program successfully applied for two new federal grants to prevent teen pregnancy. The NJ Abstinence Education Program (NJ-AEP) funds will provide services to youth populations that are at high-risk for teen pregnancy, STDs/STIs, teen births. The purpose of NJ-AEP will be to promote abstinence from sexual activity and, where appropriate, provide options that may include mentoring, counseling and/or adult supervision. The NJ Personal Responsibility Education Program (NJ PREP) will enable New Jersey to replicate evidence-based programs that have proven effectiveness in changing behaviors to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth.//2013//

Promoting healthy and safe early childhood programs is a priority for NJDHSS and its partners. In September 2005, New Jersey was awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The ECCS Team continues to work with a myriad of public and private agencies. Collaborative state partners have included the Department of Human Services, Department of Children & Families, Department of Education, Department of Environmental Protection, Department of Agriculture, Department of Labor & Workforce Development, Department of Treasury, and the Department of Community Affairs. Community partners include parent support, child advocacy and early education professional development organizations, infant/child health, mental health, and special child service providers, and early education, child care and child welfare professionals.

The priority and focus of the ECCS Grant during 2009 was development of a statewide Early Childhood Health, Development and Early Learning Website, a state of the art web-based resource for consumers and professionals. The website's breakout categories have been designed to fulfill the federal ECCS grant's twelve designated key requirements for early childhood system building and provide the necessary framework for interdepartmental systems building and collaboration. The twelve key requirements include: access to care, mental and social /emotional health, early care and education/child care, parent education, family support, financing, governance, family leadership development, provider/practitioner support, communication, standards, monitoring and accountability.
/2012/ The priority and focus of the ECCS Grant during 2010 was launching in June 2010 and promoting the website - "NJ Parent Link, New Jersey's Early Childhood, Parenting and Professional Resource Center'. //2012//

The website has been designed to function as the IT gateway for all State based services and resources, for parents and caregivers of young children, and will include direct links to all 15 executive departments, the Governor's office, the legislative and judicial branches and provide interactive parent-to-parent forums, E-serve services and professional collaborative portal features. The Website is expected to go live to the public May 30, 2010.
/2012/ Community building website features include: interactive consumer content sections; tailored subscription services; a community calendar of events; continuing education/leadership postings; a children's art gallery; an easy to navigate En Espanol feature and a translation service for over 50 languages. Numerous data collection and quality assurance markers are weaved throughout the website's features to maximize assessment capabilities and real time opportunities for collaboration and coordination of shared goals and resources within the early childhood community. The Website launched on June 1, 2010. //2012//

The NJDHSS established the New Jersey Children's Oral Health Program in 1981. The Program provides a variety of oral health education activities for children in grades pre-K through 12. The Program is regionally implemented in all 21 counties of the State with each region having an Oral Health Coordinator and other program personnel that implement program activities. Educational activities are age-appropriate and cover a variety of oral health issues including, but not limited to, good oral hygiene, fluoride as a preventive measure for tooth decay, dental sealants, healthy food choices, periodontal disease, tobacco cessation, and the prevention of oral trauma. Classroom presentations include

discussion, audio-visual materials, and extensive student participation. All Children's Oral Health Program activities can be adapted for an audience of children with special needs. Educational presentations are also provided to parents and pregnant women. Furthermore, the program staff provides in-service or workshop programs to non-dental professionals, including school nurses, public health nurses, teachers, WIC Coordinators, and social workers. During the 2009-2010 school years, over 71,000 individuals participated in formal oral health education programs provided by the Regional Oral Health Coordinators and their staff.

/2013/ During the 2010-2011 school years, over 74,000 individuals participated in formal oral health education programs provided by the Regional Oral Health Coordinators and dental hygienist staff. //2013//

III. B. 3. Preventive and Primary Care for Children with Special Health Care Needs

Special Child Health and Early Intervention Services (SCHEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family-centered care. NJ administers programs and services through the Family Centered Care Services (FCCS) Unit that ensure access to comprehensive, family-centered, culturally competent, community-based care for children age birth to 21 years of age with special health care needs. These programs partially support 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, 11 Child Evaluation Centers (CECs) of which six house Fetal Alcohol Syndrome Disorder Centers, and five Cleft Lip/Palate Craniofacial Anomalies Centers of which three also provide newborn hearing screening follow-up and three Tertiary Care Centers.
/2012/ A limited fee-for-service program is administered by FCCS to ensure eligible CYSHCN's access to medically necessary services, hearing aids, braces, orthotics, prostheses, and medications to treat asthma and cystic fibrosis.//2012//

/2013/ Despite the implementation of Grace's Law, access to health insurance through NJ FamilyCare and Medicaid a need remains for assistance to services provided through the Fee-for-Service (FFS) program for the underinsured. In addition, ineligible FFS applicants were assisted to optimally use their insurance benefits and their employers were educated when Grace's Law applied.//2013//

Seven Ryan White Part D (RWPD) Family Centered HIV Care Network Centers are also administered through FCCS and serve clients across the age span. They are funded by the HIV/AIDS Bureau, collaborate across programs and link with Title V programs and services, as needed.
/2013/CYSHCN with HIV/AIDS are referred to these Centers by Title V agencies as appropriate and case management of AIDS Community Care Alternative Program clients is coordinated across systems.//2013//

A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. Historically, SCHEIS has addressed the early identification, outreach to and the support of that special needs population through follow-up of CYSHCN by the SCHS CMUs. Typically, CYSHCN age birth – 21 years of age are identified to the SCHS CMUs in the county in which the CYSHCN resides through the BDARS and the Catastrophic Illness in Children Relief Fund; by community, family and self-referrals; and through the Social Security Administration (SSA).

A recent change in the process by which SCHEIS has streamlined SSA referrals to the SCHS CMUs is facilitating timely access to comprehensive care. The SSA referral system has moved from paper to electronic transmission. The DHSS uploads monthly county specific reports which are then viewable by the SCHS CMUs through the DHSS' secured web access. The SCHS CMUs outreach to all CYSHCN referred by SSA to offer information and referral; development of an individualized service plan; case management services as needed; linkage with community-based primary and pediatric specialty care, transition to adulthood, family support and social service supports across local, State, and federal programs. This electronic referral system eliminates the need and cost to mail SSA reports, leaving only

a minimum number of paper reports received from Disability Determinations needing to be mailed to the SCHS CMUs for follow-up. With electronic access to their county specific reports, the SCHS CMUs manage their workflow. In addition, receiving the data electronically has enabled SCHEIS to more accurately track the numbers of CYSHCN referred and served. In 2009, 13,810 CYSHCN were referred versus 7,700 in 2008 (44% increase in total unduplicated referrals); and 7,348 CYSCN served in 2009 versus 4,600 in 2008, (60% increase in unduplicated served). In 2009, 22% (2,350) of the 10,500 active children with Individual Service Plans served statewide through the County Case Management Units were identified as Supplemental Security Income (SSI) beneficiaries.

/2012/ In 2010, the number of SSA referrals received by the SCHS CMU's remained nearly level at 13,649. A quality assurance initiative was implemented to assess follow-up on SSA referrals subsequent to the change from paper to electronic referrals. Overall, the SCHS CMU's chart reviews indicated a timely and comprehensive follow-up on referrals received via the revised system. An update on follow up of SSA referrals follows in Health System Capacity Indicator 08.//2012//

/2013/ The web based SSA referral continues to be an effective referral tool and affords State Title V staffs the additional efficiency of preselecting charts in preparation for site visits. In addition, SCHS CMUs indicated that the format is easier to use and State staffs observed an improvement in reporting. See Health System Capacity Indicator 08. //2013//

SCHEIS partially supports hospital-based out-patient rehabilitative services for CYSHCN including blind and disabled CYSHCN under the age of 16 receiving benefits under Title XVI.

The Specialized Pediatric Services providers include Child Evaluation Centers, Tertiary Centers and Cleft Lip/Cleft Palate Craniofacial Anomalies Centers. Over 11,000 encounters of specialty and/or subspecialty services were reported statewide. In review of 2009 program data on client encounters by units of service, the majority of encounters (34%) were with a cardiologist, followed by neurologist (33%), gastroenterologist (32%), immunologist/allergist (32%), pulmonologist (23%), nephrologist (14%) and urologist (10%). The Centers provide evaluation and/or treatment for CYSHCN, and ensure access to care regardless of ability to pay. These health service grantees are expected to make a reasonable effort to collect payment for services rendered, however no CYSHCN is denied care because of inability to pay. The Centers are noted as Centers of Excellence by NJ Medicaid. They accept NJ Medicaid, Medicaid Managed Care, NJ Advantage, commercial insurance and/or payment on a sliding-fee commensurate with the SCHEIS Fee-for-Service/NJ Charity Care guidelines.

/2012/ Upon review of 2009 data describing pediatric specialty/subspecialty encounters, encounters across specialty providers was 180,000. Overall, in 2010, 156,000 pediatric specialty/subspecialty encounters by units of service per client were reported, the majority of encounters (54%) were with an oncologist, followed by gastroenterologist (44%), immunologist/allergist (34%), cardiologist (33%), neurologist (31%), endocrinologist (29%) and pulmonologist (26%).//2012//

/2013// Although a slight decrease in pediatric specialty/subspecialty provider encounters was noted in 2011 (150,000) vs. 2010 (156,000), demand for access to these services remained strong. Encounters with a physician (26%), physical therapist (24%) and speech therapist (23%) were most frequently cited by the Comprehensive Evaluation Centers (CEC's). Attention Deficit Hyperactivity Disorder (24%), Autism (14%) and speech disorders (12%) were the most frequently cited diagnostic categories for children served by the CEC's. Gastroenterology (14%), oncology (11%) and cardiology (11%) continue to be specialty services in highest demand by the Tertiary providers.//2013//

To ensure family participation and address cultural competency, the Centers provide written informed consent guidelines for all aspects of the evaluation, diagnostic and/or treatment services. The confidentiality of records is protected, written procedures regarding access to records is made available to all staff, and the sharing of records is determined by the parents of CYSHCN. Each Center maintains written procedures for parental consent for release of records. The Centers must comply with the Americans with Disability Act (ADA) requirements. Limited English proficiency needs are addressed

through access to foreign language interpreters and/or interpreters for the deaf. The Centers cannot discriminate through admission policies, hiring practices, or promotional opportunities on the basis of race, religion, ethnic origin, sex or handicapping conditions. CYSHCN with ongoing needs that warrant care coordination are linked with the SCHS CMU located in their county of residence.

Upon receipt of referral the SCHS CMUs conduct outreach to determine CYSHCN's needs and with parent input develop an Individual Service Plan (ISP). The ISP addresses medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the CYSHCN and/or the family as related to the child's needs. Periodic monitoring of needs and progress toward attaining services are also conducted.

In 2009, nearly 9,000 hard copy BDARS referrals were received by the SCHS CMUs, Likewise, the SCHS CMUs report new or revised data to the BDARS on a paper form. In an effort to improve efficiency, the BDARS is collaborating with the State SCHS Case Management program to develop a web based reporting and tracking system. This mechanization is eagerly anticipated to improve accuracy in reporting and tracking.

/2012/ In 2010, over 9,100 hard copy BDARS referrals were received by the SCHS CMUs for follow up. In addition nearly 14,000 referrals from the Social Security Administration, more than 400 referrals from the Catastrophic Illness in Children Relief Fund, as well as community-based referrals are all screened for registration compliance. State Case Management and BDARS staffs continue to collaborate with Case Management grantees and Rutgers University staff to develop the Case Management component of the electronic reporting and follow-up module. Screen shots have been developed, the system is being finalized and training needs are being explored for implementation in 2011. This system is anticipated to streamline registration, follow-up and tracking.//2012//

/2013/ A pilot of the BDARS' Case Management module occurred during August 2011. By January 2012, the BDARS was implemented in all 21 Case Management units. //2013//

/2013/ A slight increase in the number of BDARS referrals into SCHS CM was noted in 2011 (9180) vs. 2010 (9100). A slight increase was also noted in the number of SSI referrals from the State Data Exchange, 2011 (15,324) vs. 2010 (14,000). Overall, the CMUs assisted with nearly the same number of Catastrophic Illness in Children Relief Fund (CICRF) applications, 2010 (500) vs. 2011 (522), however an increasing trend in the source of origin for those applications was observed. In 2011, more CICRF applications originated with the assistance of an SCHS CM rather than independently by a parent and submitted directly to the State CICRF office about 50% of the time; 348 originated from the SCHS CMU and 174 had been directly submitted to the State. In addition, progress continues in the collaboration between the BDARS, SCHS CM and Rutgers University in development of the electronic case management referral system (CMRS).//2013//

The system went live in August 2011 with several pilot counties and is described in more detail in State Performance Measure 05.

Funded by the HIV/AIDS Bureau Ryan White Part D and housed in FCCS, the NJ Statewide Family Centered HIV Care Network provides a full range of high quality, culturally sensitive and coordinated HIV/AIDS medical and social support services to women, infants, children, and adolescents infected with or affected by HIV disease. The Network's vision of family health builds on an innovative integration of clinical, research, and educational services to provide the best family care possible. For over 22 years, Network physicians and staff have been at the forefront of HIV care and are committed to improving the quality of life for people living with HIV disease.

The target population served by the Family Centered HIV Care Network includes women, infants, children, and youth, and their affected family members. In 2009, 3,601 clients were served. African Americans account for 68% of the clients served, and Latinos account for 22% of the clients served. New Jersey's experience in serving children and youth indicates that the number of HIV infected newborns and children has steadily decreased in the past five years, while the number of HIV infected adolescents has

steadily increased over the same time period. In addition to collaboration with Title V MCCH and SCHEIS services and programs, the NJ Ryan White Part D program has the lead responsibility for implementing the federal HRSA Ryan White Quality Management Cross-Part Collaboration Project. Development and implementation of the plan from collaborating with the cross title NJ team and providing technical assistance on data collection has been ongoing to the Ryan White grantee agencies statewide.

/2012/ The NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth and families infected and affected by HIV disease in the State. In 2010, 3,600 clients were served by the Network. Since 2006, the number of clients aged 2-12 years has decreased from 229 to 91 in 2010. During the same timeframe, the number of clients aged 13-24 years has increased annually from 428 to 513, representing a 21% increase. This is due to the number of perinatally infected children who have aged into the adolescent program as well as new adolescent cases being identified.//2012//

/2012/ Collaboration among RWPD providers, families, SCHS Case Managers and DHS Office of Home Care staff continues to ensure a safety net of community-based care as well as to facilitate monitoring and transition of CYSHCN enrolled in the AIDS Community Care Alternative Program (ACCAP) Waiver program.//2012//

/2013/ The NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth and families infected and affected by HIV disease in the State. In 2011, 3,414 clients were served by the Network. Through diligent efforts to treat and educate HIV infected pregnant women the perinatal transmission rate in NJ remains very low. Intensive case management coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood. Most recent data indicates that we are now seeing a shift to an older HIV positive population. The number of women 45 years of age and older receiving medical care at a NJ Ryan White Part D Network agency has risen from 551 in 2005 to 829 in 2011.//2013//

For approximately 20 years, SCHEIS has worked with parent groups, specialty providers and a statewide network of SCHS CMs to provide family-centered, community-based, coordinated care for Children and Youth with Special Health Care Needs (CYSHCN) and facilitate the development of community-based services for such children and their families. The Statewide Parent Advocacy Network (SPAN) funded through SCHEIS provides parent support through a three-pronged approach titled Family WRAP (Wisdom, Resources, Advocacy and Parent-to-Parent). Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey.

SPAN and SCHEIS have continued to collaborate to identify resources to expand the number of Resources Specialists (trained support specialists) on site at the SCHS Case Management Units particularly in the southern New Jersey counties. Through the federal Parent Training Information Center (PTI) funding, the additional five Parent Resource Specialists continue to be housed in Cape May, Cumberland, Burlington, Salem and Gloucester Counties. This collaborative initiative maintains the total of case management units with part-time onsite family support to 15 counties and additional telephone support to the remaining 6 county units. Funding is being sought to further expand on-site parent support at the remaining counties through a 2009 HRSA sponsored State Implementation Grant, and notice remains pending on that application.
/2012/ Through collaboration with SPAN on the PTI grant as well as with intergovernmental and community-based partners on the HRSA funded Integrated Systems Grant (ISG), 20 part-time Family Resource Specialists are co-located and/or housed at SCHS Case Management Units statewide./2012//

In an effort to enhance family support capacity, the SCHEIS collaborated with SPAN, the NJ Academy of Pediatrics Pediatric Council on Education and Research (PCORE), and other community partners to develop grant applications for supplemental funding. Recent successful collaborations with SPAN include the HRSA State Implementation Grant for Integrated Community Systems (Integrated Systems Grant or ISG 1), and the Administration on Developmental Disabilities' Military 360 initiative for military families at the combined Fort Dix McGuire Air Force Base and Lakehurst Naval Air Station mega-base.

/2012/ The ISG 1 collaborative application was approved and funded for $300,000. A subsequent HRSA sponsored Autism collaborative grant application was developed to extend the ISG 1 activities to address CYSHCN with autism. This subsequent grant is referred to as the Autism Integrated System Grant or ISG 2. Both the ISG 1 and ISG 2 grants provide funding to enhance capacity for additional SPAN Resource Parents to be housed at and/or support families served by SCHS Case Management Units and Autism Clinical Enhancement Centers.//2012//

/2013/ The ISG 1 and ASG 2 partnerships of intergovernmental agency representatives, community-based organizations, youth with special health care needs and their families collaborated to promote activities that addressed the six Core Outcomes and strengthen NJ's community-based system of services mandated for CYSCHN. The activities are integrated into SPM 02-06. Quarterly meetings of the full Consortium of Care provided opportunities to discuss strategies and incorporate autism into the ISG model, and monthly conference calls among the core team members, SPAN, NJ Academy of Pediatrics Pediatric Council on Research and Education (NJ PCORE), and Title V, facilitated project implementation.//2013//

C. Organizational Structure

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Celeste Andriot Wood, Assistant Commissioner, Division of FHS.
/2012/ Gloria Rodriguez accepted the position of Assistant Commissioner for Family Health Services in December 2010 when Celeste Andriot Wood retired. Gloria Rodriguez was the former Director of SCHEIS.//2012//

D. Other MCH Capacity

The following section describes the number and location of staff that work on Title V programs.

Maternal and Child Health Services (MCHS) Unit

Maternal and Child Health Services (MCHS) is comprised of three program managers, 24 professionals, and 14 support staff. All staff members are housed in the central office. Dr. Lakota Kruse is the Service Director for MCHS. Dr. Kruse is a Pediatrician and an MCH Epidemiologist who has been with the NJDHSS since 1993. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds.

Reproductive and Perinatal Health Services is staffed by 10 professionals and 3 support personnel and a Program Manager, Sandra Schwarz, RNC,MS. The program is responsible for the regional MCH Consortia, Healthy Mothers, Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Healthy Start projects, Family Planning, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, post partum mood disorders initiative, Access to Prenatal Care Initiative, and preconceptual health. Resources for staff have been from Federal MCH Block, Federal Title X, Preventive Health and Health Services Block, and Healthy Start Grants.

/2013/ Reproductive and Perinatal Health Services is staffed by seven professionals and three support personnel and a Program Manager, One nursing professional was added to the program to assist with the MEIC HV grant. Several professional staff members participate in the various subcommittees of the Home Visiting Work Group. The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Access to Prenatal Care Initiative. //2013//

Child and Adolescent Health Services is comprised of a staff of 7 professionals, 5 support personnel, 1 paraprofessional and a Program Manager, Cynthia Collins. Resources include: State MCH funds, Federal MCH, and Preventive Health and Health Services Block Grants, Centers for Disease Control and Prevention cooperative agreements for Lead and School Health, an Early Childhood Comprehensive Systems (ECCS) Implementation grant from HRSA, MCHB and State Lead funds. All staff members are housed in the central office. Child and Adolescent Health has oversight by a Program Manager with responsibilities that address childhood lead poisoning and prevention and adolescent health in middle and high schools. Childhood lead poisoning and prevention has one Primary and Preventive Health Services Coordinator, four professionals and 1 paraprofessional. The Health Resources and Services Administration (HRSA) funds New Jersey's Early Childhood Comprehensive System grant and its activities are coordinated by one professional staff position. Adolescent health currently includes the Community Partnership for Healthy Adolescents initiative and the Centers for Disease Control's Coordinated School Health model and is staffed by two professional positions. Child and Adolescent Health staff has varied professional backgrounds including nursing, nutrition, health education, research and data analysis.
/2012/ The Child and Adolescent Health Program is comprised of a staff of 9 professionals (6 of which work in childhood lead poisoning and prevention, 4 support personnel, 1 paraprofessional

and a Program Manager, Cynthia Collins. One new professional staff person brings a legal background to the Program; the other is a MSN, RN.//2012//

/2012/ Two additional funding resources were applied for and approved from DHHS, ACF for the Title V Abstinence Education Program and the Personal Responsibility Education Program (PREP). The Community Partnership for Healthy Adolescents initiative ended June 30, 2010. //2012//

***/2013/* The Child and Adolescent Health Program is comprised of 6 professional staff (4 in Healthy Homes/Childhood Lead Poisoning and Prevention unit, 2 administrative support staff, 1 paraprofessional and a Program Manager, Cynthia Collins, MS, CPM. One professional retired, one transferred and one accepted a promotion in WIC Services. DHSS was awarded the CDC Healthy Homes 3 year cooperative agreement September 1, 2011. Unfortunately, grant funding will end August 31, 2012 due to federal funding cuts. //2013//**

To build state and local capacity for addressing the health and development needs of children and adolescents through coordinated school programs the NJ Department of Education (NJDOE), in partnership with the NJDHSS, applied for and was awarded a five-year cooperative agreement in March 2008 by the Centers for Disease Control and Prevention (CDC.) A portion of the CDC funding is allocated to NJDHSS, through a Memorandum of Agreement, for one full-time equivalent professional position that functions as the DHSS School Health Coordinator.

Adolescent Health released in February 2010 a competitive Request for Applications for organizations interested in applying for "Building a Coordinated School Health (CSH) System in New Jersey". Three grants, each located in one of three New Jersey regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's model in at least eight public middle- and/or high-schools of public school districts, for a total of at least 24 schools. It is the intent of this grant to provide funds for a three year pilot project period; however, budgets will be annually submitted and approved.

In May 2008, two months after the award of the CDC cooperative agreement with the NJ Department of Education (NJDOE), the NJDHSS was awarded a 5 year CDC cooperative agreement to the Office of Nutrition and Fitness (ONF) for state leadership and coordination of nutrition, physical activity and obesity strategies (NPAO). Through this cooperative agreement, DHSS will collaborate with the existing infrastructure, which includes NJDOE, the Department of Agriculture, the Department of Transportation (DOT) and the Department of Children and Families (DCF) for the implementation of state determined strategies focused in the school venue to prevent obesity.

/2012/ The evidenced based school strategies include:
1) Advocating for an increased school meal subsidy to enable schools to offer a variety of healthy foods and beverages and to prepare appealing school meals.
2) Creating/ensuring adequate school infrastructure to prepare a variety of healthy, appealing, kid-friendly fruits and vegetables or provide schools with adequate access to resources to purchase such foods.
3) Working to enhance the minimum standards in the state school wellness policy around nutrition, physical activity and TV viewing. The policy will also encourage local districts to locate schools where students can safely and easily walk and bike to school.
4) Promoting and support active school-based wellness councils that implement school wellness policies; councils will include community and school representatives.
5) Ensuring that all students are actively engaged in their Physical Education class.
6) Providing students with diverse and developmentally appropriate activities to meet individual needs and interests.
7) Providing facilities that are conducive to learning (with respect to class size, equitable space, sufficient equipment and technology and safe and clean facilities).
8) Working to ensure that schools provide a variety of quality activities during the school day to encourage students to be physically active (such as recess, activity breaks, energizers and before- and after-school physical activity programs).//2012//

/2013/ In June 2012, the School Strategy Workgroup disseminated a Tool Kit to assist ShapingNJ partner organizations with implementation of school nutrition strategies.//2013//

The next steps for the NPAO project is establishing comprehensive work groups per each strategy. These groups will identify the federal, state and local policy barriers and opportunities specific to implementation of work. The strategy workgroups will identify specific tasks for their strategy. The ultimate goal for all school workgroups is to empower the full partnership to advocate for policies that will support implementation.

The Children's Oral Health Education Program comprised of 1 professional and 1 support staff who reports to the Office of the Director. Dr. Beverly Kupiec-Sce coordinates the program which provides age appropriate oral health education to school age children.
/2012/ Classroom-based education is targeted to the high-need/high-risk areas while a system of Oral/Dental Health teaching kits are available through a loaner system. In addition, the Program administrates a voluntary fluoride mouth rinse program, "Save Our Smiles" to schools in areas where the water is not optimally fluorinated. The Program also develops and distributes the NJ Dental Clinic Directory, "Dial A Smile" which is a central source of information for public dental clinic services. The annual school newsletter, "Miles of Smiles" is distributed to school nurses, teachers, and public health nurses Statewide. //2012//

The mission of the Maternal and Child Health Epidemiology Program (MCH Epi) is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. MCH Epi is comprised of three research professionals, and two support staff. All research staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The Pregnancy Risk Assessment Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program. Ingrid Morton is the Program Manager for MCH Epi. The MCH Epi program was integrated into the MCHS Unit in April 2010.

The Office on Nutrition and Fitness (ONF) within FHS consists of a Director, Peri Nearon, with 7 professional staff and 1 secretarial support staff. Funding sources include: a Centers for Disease Control and Prevention cooperative agreement for Nutrition, Physical Activity and Obesity (NPAO) and state MCH funds. All staff members are housed in the Division of Family Health Services. In addition to the CDC cooperative agreement for NPAO, the Office also includes the Healthy Community Development Leaders' Academy and mini grants. ONF is responsible for addressing obesity prevention throughout the lifecycle. ONF staff have varied professional backgrounds including nutrition, public health, environmental studies, research and data analysis.

/2012/ Staffing within ONF consists of a Director, Peri L. Nearon, 8 FTE professional staff and 1 FTE secretarial support staff. Current financial support includes a CDC cooperative agreement for NPAO (2008 - 2013); supplemental funding from CDC for Communities Putting Prevention to Work - State & Territorial Initiatives (CPPW - STI) (Jan 1, 2010 - Dec 31, 2011) for Healthy Communities, Child Care Initiative & Breastfeeding initiatives; state MCH funds and Preventive Block funds. Funds have been leveraged within the state to secure funding from The Robert Wood Johnson Foundation and the Partners for Health Foundation (Mountainside Hospital) to offer grants to additional communities. The ONF also includes the Healthy Community Development Leaders' Academy held bi-annually and distribution of mini grants. Efforts of the ONF are aimed at obesity prevention throughout the life cycle through policy & environmental change with a focus on disparate populations that carry the burden of chronic disease. The goal is to make healthy choices easier for NJ residents.//2012//

/2013/ **The Office on Nutrition and Fitness (ONF) within FHS consists of a Director, Peri Nearon, with 7 professional staff and 1 administrative support staff. Funding sources include: a Centers for Disease Control and Prevention cooperative agreement for Nutrition, Physical Activity and Obesity (NPAO) and state MCH funds. All staff members are housed in the Division of Family Health Services. In addition to the CDC cooperative agreement for NPAO, the Office also includes the Healthy Community Development Leaders' Academy and mini grants. ONF is responsible for addressing obesity prevention throughout the life cycle. ONF staff have varied professional backgrounds including nutrition, public health, public administration, environmental studies, research and data analysis.//2013//**

Special Child Health and Early Intervention Services (SCHEIS)

Special Child Health and Early Intervention Services (SCHEIS) consist of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and the Early Intervention System.
/2012/ Dr. Marilyn Gorney-Daley is the Director of SCHEIS. Dr. Gorney-Daley was named Director of SCHEIS in December 2010, when Dr. Gloria Rodriguez, former Director of SCHEIS, accepted the position of Assistant Commissioner in Family Health Services. Dr. Gorney-Daley is board certified in General Preventive Medicine and Public Health; she has worked in DHSS since 1995 and had served as Medical Director for SCHEIS previously. All SCHEIS staff members are housed in the central office.//2012//

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), and Autism, and the Early Hearing Detection and Intervention Program. The EIM Program is comprised of a staff of ten professionals, seven support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has over 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and two Centers for Disease Control and Prevention cooperative agreements (EHDI and Birth Defects Surveillance), and the Autism Medical Research and Treatment Fund.

/2013/ The EIM program now has nine professionals as one of their professional staff retired. The program will request an exemption to the hiring freeze in order to back-fill the position.//2013//

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 7 professionals and three support staff and a Program Medical Director, Lorraine Freed Garg, MD, MPH.

The Family Centered Care Program (FCCP) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded case management units, Family WRAP family support services, 11 child evaluation centers which include 6 FAS Diagnostic Centers, 5 cleft lip/cleft palate centers, 3 tertiary care centers, two organ donor and tissue sharing donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of seven professionals, three support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Bonnie Teman, RN, MSN. Ms. JoAnn Ayres, RN, M.Ed., and Ms. Suzanne Canuso, RN, MSN, recently joined FCCP to coordinate Specialized Pediatric Services and staff Case Management.

/2012/ Ms. Felicia Walton, BA, joined SCHS Case Management to assist with program monitoring and training related to the roll out of the electronic BDARS, however 2 Public Health Nursing vacancies remain.//2012//

The Early Intervention System is headed by Terry Harrison, Part C Coordinator. This System provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

E. State Agency Coordination

This sections describes relevant organizational relationships between FHS and the State Human Services agencies (mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including MCH Consortia) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources which enhance the capacity of the Title V program.

This section also describes the plan for coordination of the Title V program with (1) the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services.

/2013/ In an effort to better leverage public and private funds and to reduce infrastructure costs, the Department made the commitment to reduce the number of MCHC to 3. Given the reduction from 5 Maternal and Child Health Consortia to 3, health service grants providing infrastructure are being reduced to support key staff positions in the remaining consortia based on the number of births and geography. Grant funding saved by consolidation will be redirected to direct services for clients in the Perinatal Initiative using a formula based on the number of births by region.//2013//

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. Specific programs include the activities of the Access to Prenatal Care Initiative, eight Healthy Mothers Healthy Babies Coalitions, Perinatal Addictions Prevention Projects, Post Partum Depression education projects, preconceptional health counseling, regional Childhood Lead Poisoning Prevention Coalitions, and facilitation of the Black Infant Mortality Reduction Initiative.

Promoting healthy and safe early childhood programs is a priority for NJDHSS and its partners. In September 2005, NJ was one of 18 states that were awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The focus of the ECCS Grant was development of a statewide Early Childhood Health, Development and Early Learning Website, a state of the art web-based resource for consumers and professionals. The goal of the website and portal will be to improve the accessibility, coordination and delivery of information and services to children and their families, and to improve the communication capabilities for ongoing service collaborations and policy development. Following completion in June 2010 of the website and portal, early childhood systems building efforts will continue with the rebuilding and expansion of the NJ ECCS Team. The NJ ECCS team will sustain the active communication and systems networking necessary to maintain NJ early childhood health, development and early learning goals and will include a total of 150 representatives from all 15 executive departments, the governor's office, the legislative and judicial branches, as well as community stakeholders. The team is expected to include 15 (10%) parent representatives.

School health collaboration and coordination is accomplished through a school health liaison position within the Adolescent Health section. The Departments of Education and DHSS staff have developed joint statements and a Strategic Plan for School Age Health signed by both Commissioners. The strategic plan affirms both departments' support for comprehensive school health programs, with a particular focus on the 31 special needs school districts.

/2012/ The school health liaison position is funded with CDC funding through a MOA with the DOE. The prior existing joint statements and Strategic Plan for School Age Health, created in

2004, have been updated by the 5 year Strategic Plan as required by the CDC cooperative agreement. The strategic plan reaffirms the DOE and DHSS commitment to coordinated school health (CSH) and continues to target schools in municipalities with students likely to have high-risk behaviors.//2012//

/2013/ Through a competitive application process, Ms. Collins, Program Manager was selected to participate in the 2012-13 MCH PHLI Cohort and complete the project proposal: A Comprehensive Public/Private State Plan for School Health. The audience includes all State departments with school health programs and/or services and interested statewide organizations whose goal is in meeting the health (physical, emotional and/or social) needs of NJ students. Identified partnerships, include but are not limited to: DOE, DCF, NJ Department of Agriculture, DEP, DOT, DHS, Rutgers, Horizon NJ Health, AAP, ASCD, School Boards Assoc, State School Nurses Association, Association of Health and Physical Education, Recreation and Dance, Alliance for a Healthier Generation, and American School Health Association. The DHSS CDC funded school health liaison position (MOA with the DOE) participated in development of the year four strategic plan activities and executed training events for DOE and DHSS grantee schools. Workplan events included: 1) the Wellness Team Leadership Academy; 2) Food Service Director Panels; 3) assemblies coordinated with Olympian Joetta Clark Diggs' son; 4) *ShapingNJ* School Strategy workgroup addressing the school nutrition policy and school wellness teams; and 5) CSH stakeholder communications regarding CSH progress and resources.//2013//

To address school health and adolescent risk taking behavior, DOE formalized a partnership with DHSS, through the use of a MOA, for implementation of CDC's Coordinated School Health (CSH) model. In addition to DOE and DHSS, there is state department representation from: Agriculture (NJDA); Children and Families (DCF) School Based Youth Services Program, Environmental Protection (DEP), the Juvenile Justice Commission (JJC) and Transportation's (DOT) Safe Routes to School.
/2012/ DHSS is updating the "Coordinated School Health Departmental Directory" and will be looking to expand the Directory to include CSH Departmental partners: DOE, DCF, NJDA, DOT, DEP, DHS and JJC.//2012//

/2013/ Since September 2011, DHSS has been collaborating with Montclair State University to provide field experience for MPH candidates. The current student intern is finalizing the State Department Directory of School Health Programs and Services for posting on the FHS website and available sources of funding for community-based agencies and schools interested in school health.//2013//

The Teen Pregnancy Prevention Programs (AEP and PREP) targets high-risk youth population 30 state-identified municipalities. The programs are primarily school and community based. All 7 PREP grantees will implement evidence-based program models. Through a Memorandum of Agreement with the Montclair State University, Dr. J. Donnelly will provide evaluation services for the AEP. A contact agreement for PREP evaluation services is in process. A HIV, STD and Teen Pregnancy Prevention workgroup comprised of staff from the DOE, DCF & DHSS meets quarterly to share activities and resources and to ensure that there is no overlap of services with other SBYS.

The *ShapingNJ* Partnership - the state partnership for nutrition, physical activity and obesity prevention currently has 180 plus partners, from agencies and organizations across the State, committed to policy and environmental changes that will make the healthy choice the easy choice. All efforts are aimed at decreasing obesity and chronic disease in the state by addressing nutrition, physical activity and obesity (NPAO) prevention strategies in five (5) settings: schools, communities, child care centers, worksites and healthcare facilities.//2013//

The Children's Oral Health Program is administered is organized into 3 regional programs and covers all 21 counties of the State. Program services activities are targeted to high-need/high-risk areas with non-where the water is not optimally fluoridated community water and work with schools which have a high proportion of students enrolled in free-and reduced lunch programs. All 3 regional programs have similar

scope of services and the programs provide the same types of activities. Through a Memorandum of Agreement with the State's dental school, the University of Medicine and Dentistry of NJ, New Jersey Dental School, a licensed dentist is available to provide dental consultation to the Program.

Coordination between the State's Primary Care Office and FQHCs continues. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office. The Office of Primary Care has provided cost-base reimbursement to qualified FQHCs for eligible visits by uninsured and underinsured individuals since 1991. Funds to compensate the centers for uninsured visits are derived from the Health Care Subsidy Fund, which is financed by an assessment on hospital operating revenues. The portion of the annual assessment that is allocated to the FQHCs is $40 million in SFY 2010 and $40 million in SFY 2011.

/2013/ The portion of the annual assessment that is allocated to the FQHCs is $45 million in SFY 2011 and $46.4 million in SFY 2012.//2013//

The FQHCs operate in 20 of NJ's 21 countries. The 20 FQHCs have a combined 95 licensed satellite sites throughout the State. As a consequence of expansion and capacity building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In 2009, almost 150,000 uninsured persons were services and over 400,000 uninsured visits reimbursed. Overall, there were almost 400,000 patients and over 1 million visits provided by the state's network of FQHCs. Capacity of the FQHCs has expanded in evening and weekend hours. The average FQHC site is operational 47 hours per week. All FQHCs operate "call coverage" services. Some FQHCs provide "urgent care" programs that extend far beyond the normal work day, thus allowing patients access to care in a primary care setting as opposed to a hospital emergency department.

/2012/ The 20 FQHCs have a combined 94 licensed satellite sites throughout the State. In 2010, almost 178,775 uninsured persons were services and over 500,000 uninsured visits reimbursed. Overall, there were almost 400,000 patients and over 1.2 million visits provided by the state's network of FQHCs. The average FQHC site is operational 54 hours per week.//2012//

/2013/ The FQHCs operate in 20 of NJ's 20 countries. The 20 FQHCs have a combined 96 licensed satellite sites throughout the State. As a consequence of expansion and capacity building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In SFY 2011, almost 195,000 uninsured persons were services and over 440,000 uninsured visits reimbursed. Overall, there were almost 425,000 patients and over 1.3 million visits provided by the state's network of FQHCs.//2013//

The NJ Title V CYSHCN program collaborates with programs and services across State government to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. The Department of Human Service (DHS) is the largest department in NJ State government, and although Title V collaborates with many of its health programs and support services, those directly addressing medical, dental, developmental, rehabilitative, mental health, and social service are essential. Title XIX and Title XX services are administered by DHS, and provide critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need.

/2012/ SCHS Case Management collaborates with intergovernmental partners in the DHS' Office of Home Care and the DHS' Office of Developmental Disabilities, and DHSS' Long Term Care in the development of standardized case management waiver training. Standardized training of SCHS CMU's using the mandatory training module was conducted statewide. In addition, as core partners in the ISG, the Title V CYSHCN program collaborates with SPAN, the NJ Academy of Pediatrics Pediatric Council on Research and Education, DHS, the Department of Children and Families, as well as other intergovernmental and community-based partners to plan and implement interventions to address the six core outcomes for CYSHCN.//2012//

/2013/ In the Spring 2011, the NJ DHS introduced its Medicaid Waiver concept paper proposing structural consolidation and reform of NJ's Medicaid program. Public input was sought and NJ's Comprehensive Waiver application was submitted to CMS. Key elements of the Comprehensive Waiver (pending CMS approval) will close NJ FamilyCare to new parents, eliminate prior quarter coverage for new enrollees-excluding those eligible for nursing home placement, and enhance premium assistance programs to maximize third party coverage to ensure Medicaid remains payer of last resort. Proposed benefits to families of CYSHCN include consolidation of waiver programs, integration of behavioral health for those not currently covered by the Children's Behavioral Health System, expansion of home and community-based services and supports for people with developmental disabilities consistent with the Affordable Care Act, expansion of home and community-based services and draw down of additional federal matching funds, and strengthening of HMO contract language to place more responsibilities on HMOs for reporting fraud and abuse. By the close of 2011, Medicaid mandated enrollment into managed care, including waiver clients. Title V facilitated the identification of children whose families needed to self-select an HMO that best met their child's needs. Moving forward, DHS proposes to move services for children with developmental disabilities to the Department of Children and Families, as well as reconfigure and rename some programs currently serving children at risk for abuse and neglect. Title V's input in this process is ongoing, and updates are shared with community-based organizations and families to facilitate their participation in the process. Examples of Title V input includes participation at meetings with DHS Medicaid, Office of Managed Care and Office of Home Care staffs; contribution to Frequently Asked Questions posted on DHS' website; attendance at waiver trainings provided by DHS Office of Managed Care and the Office of Home and Community Based Services; sharing SCHS Case Managers', families of CYSHCN's, and State staffs' actual experiences in accessing care through the revised system; and participation at quarterly Medical Assistance Advisory Council and Global Options waiver meetings.//2013//

On the local level, the SCHEIS programs, SCHS CMUs, SPS, and RWPD, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county based Boards of Social Services and Medicaid Assistance Customer Care Centers. They collect and report program data including insurance status. That report is compared with Medicaid data in determining CYSCHN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for supports/advocacy.
/2012/ Updates on the roll out of federal healthcare reform and its benefits for NJ families of CYSHCN are shared with SCHEIS programs by DOBI through presentations at meetings and updates on the Department of Banking and Insurance website.//2012//

/2013/ The Family Centered Care Services' health service grantees continue to screen CYSCHN for insurance status and referral to resources to facilitate access to Medicaid and/or insurance. Likewise, the SCHS CMUs, Specialized Pediatric Services providers and the Ryan White Family Centered HIV Care Network assist families to navigate Medicaid managed care and/or coordinate access to care through third party providers. //2013//

FHS maintains a memorandum of agreement with the DHS Medicaid to facilitate operation of the SCHEIS Fee-for-Service program. It ensures access to medications for the treatment of children with asthma and cystic fibrosis through NJ Medicaid participating pharmacies. Children birth to 21 years of age referred for this program are linked with the SCHS CMU in their county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS. Likewise, State DHS staff that administer Medicaid durable medical equipment services and SCHEIS Fee for Service staff collaborate on technology and resource trends related to hearing aids, braces and orthotics.

/2012/ For example, collaboration among DHS Medicaid, SCHS Case Management, the State audiologist, and hearing aid dispensers resulted in clarification of billing codes for bone conduction hearing aids and related services./2012//

The State SCHEIS office collaborates with DHS offices and programs to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waivered services. 100% of CYSCHN served through SCHS programs; SCHS CM, Pediatric Specialty Care Providers (SPS) including Child Evaluation Centers (CECs), Cleft Lip/Palate, Craniofacial Anomalies Centers and Tertiary Care Centers as well as the Ryan White Part D Family Centered HIV Care Network are screened for insurance status and/or referred for Medicaid/NJ FamilyCare or waiver programs, as applicable.

The DHS Office of Medicaid Managed Care (MMC) Quality Assurance is helpful in ensuring that families of CYSHCN are accessing comprehensive quality managed care, and that specialty providers are enrolled and coding correctly. Periodically, ad hoc committees are convened to problem solving provider reimbursement questions.

In 2010, major changes are occurring in NJ Medicaid Managed Care, with two of the Medicaid health maintenance organizations acquiring two other currently existing plans and a new HMO being awarded. Over a 6 month period, 100,000 Medicaid managed care enrollees are targeted to change health plans. To facilitate this process SCHEIS is collaborating with the Office of Medicaid Managed Care Quality Assurance to provide outreach and support to families and specialty providers.
/2012/ As a result of in-reach to families of CYSHCN by SCHEIS provider agencies enrolled in Medicaid Managed Care and affected by HMO restructuring, families were assisted through the transition. This included redirecting families to Medicaid's hotline, technical assistance on access to specialty providers and promoting awareness about Medicaid Managed Care, Care Coordination. A proposal in the State 2012 budget mandates the enrollment of Fee-for-Service Medicaid recipients into Medicaid managed care. The DHSS is collaborating on this initiative which is intended to be implemented in July 2011. The Department will take steps to support families through the process.//2012//

/2013/ Subsequent to implementation of mandatory MMC, a need to clarify the coordination of third party liability and Medicaid benefits was noted. To that end, the DHS Office of MMC developed a guide to understanding health coverage in NJ. Title V facilitated distribution of "When You Have Medicaid and Other Insurance, Balance Billing, Choosing Providers and Other Advice on Third Party Liability (TPL), to FCCS' grantees and families of CYSHCN. Title V also consulted with the DHS Office of MMC, families and providers and revised "Finding Your Way through Medicaid Managed Care", a brochure routinely distributed to families of CYSCHN on Social Security Income (SSI), to reflect changes in Medicaid process and vocabulary. In addition, during the fall 2011 mandatory enrollment of CYSHCN in the CRPD and ACCAP waiver programs, Title V identified, educated and assisted those nearly 100 families with enrollment into MMC organizations.//2013//

The DHS disability specific programs facilitate access to comprehensive care and supports for CYSHCN. Likewise, they commonly consult with State SCHEIS staff and our network of providers to ensure that families are linked to specialty services. Blind and/or visually impaired CYSHCN are referred to the DHS Commission for the Blind and Visually Impaired (CBVI). The CBVI staff provides itinerant education services for infants and toddlers age birth to 3 years of age and their families. Visually impaired children age 3-21 years, and deaf/blind CYSHCN age birth-21, are referred for assessment and evaluation of visual abilities, instruction in Braille and related skills, family supports, educational supports, adaptive aids and texts, assistive technology, and other supports.

The DHS, Division for the Deaf and Hard of Hearing (DDHH), partners in planning access to care and service delivery for CYSHCN with impaired hearing. SCHEIS staff and DDHH staff cross refer CYSHCN and their families for services and supports. Advocacy, employment and vocational opportunities, sign language interpreter services and assistance with social, legal, medical, educational, and recreational issues are examples of services that SCHS CM and the Specialized Pediatric Services providers refer CYSCHN to DDHH.
/2012/ Collaboration with DDHH includes planning and implementation of Family Learning Day scheduled for spring 2011. In preparation, a series of focus groups are in development to gain

family input on needs for services to support families of CYSHCN with hearing impairment in the community.//2012//

/2013/ Title V State staffs, SCHS CMUs, and SPAN participated in the planning and development of the 2011 event.//2013//

The Early Identification and Monitoring (EIM) Program has multiple collaborations with the DDHH, in the NJ DHS. The EIM Program Manager is the DHSS representative on their Advisory Council. DHSS has partnered with DDHH on numerous outreach programs for consumers, and printed brochures. **/2012/Collaboration between EIM, FCCS, and DDHH is planned in 2011 to translate and distribute a seminal brochure describing Grace's Law benefits for hearing impaired children and youth, and to target Spanish speaking families with outreach and support.//2012//**

/2012/ In April 2011, the Early Hearing Detection and Intervention Program partnered with DDHH and the Statewide Parent Advocacy Network (SPAN) to host the 4th biennial Family Learning Day. The goal of Family Learning Day is to bring together resources and information to give families opportunities to learn about advocacy strategies and services available for children with hearing loss. From presentations to exhibits, the day is devoted to allow family members to explore and learn and includes the following activities: a student panel of successful deaf and hard of hearing students, workshops and panel discussions from professionals in the field of hearing loss, and opportunities to network with other families who have children with hearing loss. Supervised activities are available throughout the day for children with hearing loss and their siblings. This year, the day is funded from HRSA universal newborn hearing screening grant funds, a CDC conference support grant, and DHSS, DDHH, and SPAN.//2012//

/2013/ The Early Hearing Detection and Intervention program (EHDI) collaborated with the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS), to allow nurses responsible for health outcomes of children under DYFS supervision to have read-only access to hearing screening modules that are in the New Jersey Immunization Information System. Continued partnership with five of the Federally Qualified Health Centers (FQHCs) has allowed for hearing re-screening for uninsured families at these locations.//2013//

/2013/ The EHDI program collaborated with the Statewide Parent Advocacy Network and the National Hands and Voices organization to host a statewide event on March 31, 2012 for families with children who are deaf and/or hard of hearing. The purpose of this meeting was to discuss what family supports are needed for families having children who are deaf and/or hear of hearing and to discuss options for future efforts for improving family support.//2013//

Collaboration between SCHEIS staff, SCHS CM and/or Specialized Pediatric Services providers and the DHS, Division of Family Development (DFD) is essential in coordinating access to care and social services for many of NJ's most vulnerable CYSHCN and their families. The primary tasks of DFD include directing NJ's welfare program, Workfirst NJ (WFNJ), and providing funding, information management services, and administrative support to the county and/or municipal welfare departments that implement the federally funded Food Stamps food assistance program. The DFD also oversees child care licensing, Kinship supports for families, and child support. The federal SSI benefit program for aged, blind or disabled individuals is also supplemented by DFD. WFNJ recipients who may be eligible for federal SSI benefits can now get free legal help. The DFD has established an agreement with Legal Services of NJ (LSNJ) to assist recipients in either filing for SSI benefits or appealing a denial of benefits.

The DHS Division of Disabilities Services (DDS) and SCHEIS collaborate to promote and facilitate independence and participation for people with disabilities in all aspects of community life. Through its system of Information and Referral (I&R), the DDS supports active information exchange regarding community services and fosters coordination and cooperation among government and community-based agencies. The I&R Specialists commonly refer families of CYSCHN to the SCHEIS CECs, Tertiary Care Centers and Cleft Lip/Palate and Craniofacial Anomalies Centers; SCHS CM and family supports. In addition, SCHEIS refers families to the Traumatic Brain Injury (TBI) Fund, TBI Waiver and Personal

Preference: NJ Cash and Counseling Program; and the Medicaid Personal Care Assistant (PCA) services. The SCHEIS regularly uses these DDS resources to assist families of CYSHCN to find health and transition to adulthood supports. In addition, the SCHS CMUs are the contracted case management vendors for the AIDS Community Care Alternatives Program (ACCAP) waiver; and Community Resources for People with Disabilities (CRPD) waiver.
/2012/ The DDS produces a valuable directory of State, federal, and disability specific resources annually. SCHEIS contributes updates on programs and services and widely distributes "Resources" at consumer and provider trainings. In addition, the State Case Management staffs meet with State DDS waiver staff to ensure access to waivered services. State and local Case Management staffs participated in the development and implementation of waiver trainings in 2010.//2012//

/2013/ The DHS DDS Office of Home Care, Title V and SCHS CMU staffs communicate regularly on waiver procedure. Waiver training was conducted on a statewide Waiver CM format as well as through participation at the SCHS CMU Coordinator meetings. In addition, a revised DDS waiver training manual is in development. A formal statewide Medicaid Comprehensive Waiver training was conducted in 2011, attended by SCHS CMUs and Title V staffs, and reinforced communication across systems.//2013//

Statewide mental health services for CYSHCN with serious and persistent mental illnesses are coordinated by the DHS Division of Mental Health Services (DMHS) and the Division of Addiction Services (DAS). Supporting CYSHCN with emotional/behavioral co-morbidities and their families is a challenge. The SCHEIS' CECs, FASD's, and Tertiary Care Centers serve as a vital community-based asset for families and mental health providers to consult for comprehensive evaluations and treatment of CYSHCN. Likewise, the SCHS CMU's link CYSHCN with emotional behavioral needs to the mental health and specialized pediatric providers to coordinate access to care across those systems.

In operation for over 20 years, the Catastrophic Illness in Children Relief Fund (CICRF) Commission administers a financial assistance program for NJ families whose children have an illness or condition otherwise not fully covered by insurance, State or Federal programs, or other source. By legislative mandate, the FHS sits on the CICRF Commission. The FHS maintains a memorandum of agreement (MOA) with the CICRF program to formally refer children birth to 21 years of age whose families have accumulated medical debt for the care and treatment of their children's medical condition. All applications received by the State CICRF program are forwarded to the SCHS CMU in the CYSHCN's county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS.
/2012/ As the SCHS CMU staff conduct intake on new referrals and/or monitoring of active clients' needs, insurance status and outstanding medical debt are queried. In 2010, the SCHS CMU's assisted families to process 525 applications statewide with 318 awards totaling $ 7.1 M.//2012//

/2013/ In compliance with CICRF's intergovernmental MOA, the Title V State staffs conduct outreach through the State BDARS mailings and by the SCHS CMU follow-up on new referrals, as well as through public speaking engagements, webinars and community events. Cross-referral of clients identified to CICRF and SCHS CM occurs regularly, for those both eligible and ineligible for CICRF. In 2011, the CICRF application was posted online, and CICRF is developing functions to enable electronic submission. State Title V staffs are meeting with CICRF to establish protocol to support transmission of referrals to the SCHS CMUs for more rapid linkage to community supports. A nearly 10% increase in the number of applications for assistance generated by the SCHS CMUs was noted in 2011 (382) as compared to 2010 (348).//2013//

The NJ Council on Developmental Disabilities (NJ CDD) functions in accordance with the federal Developmental Disabilities Assistance and Bill of Rights Act, and in NJ State government by N.J.S.A. 30:1AA 1.2 and is codified in Title 10 of the State Administrative Codes. According to State statute the Title V agency has a seat on the NJ CDD. The purpose of the NJ CDD is to engage in advocacy, capacity building, and systemic change that contribute to a coordinated, consumer and family-centered, consumer and family-directed comprehensive system that includes needed community services,

individualized supports, and other forms of assistance that promote self determination for individuals with developmental disabilities and their families.
/2012/ In 2010, State SCHEIS staffs collaborated with NJ CDD on committees, policy development and the Partners in Policymaking (PIP) leadership training program.//2012//

/2013/ Collaboration in referral to families served by Title V to participation in PIP continues, and State staffs participated in the leadership training program.//2013//

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42:CFR446.10 of the Social Security Act. The 15 member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems.
/2012/ Updates in Medicaid programs and services (i.e. change in transportation provider agency) are shared through MAAC meetings and disseminated to SCHEIS provider grantees. This communication is helpful in assisting consumers to access community-based services in a timely manner.//2012//

/2013/ State staffs' participation at quarterly MAAC meetings served as a forum for discussion, information sharing and public input for development of the Comprehensive Waiver.//2013//

The Office of Special Education Programs, within the Division of Student Services in the DOE, has oversight responsibilities for the provision of education and related support services to students with disabilities, aged 3 to 21. In addition to local level collaboration and child find between school districts and the SCHEIS programs and services; i.e., child study team referral to CEC's for comprehensive evaluations, pre-school handicapped transition planning conducted by Early Intervention Services (EIS) and SCHS CM, and collaboration between school nurses and SCHS CM, the State DOE and DHSS Title V programs serve on committees, collaborate on policy and implement programs.

In order to ensure access to health insurance and benefits to enrolled CYSHCN, SCHEIS collaborates with the Department of Banking and Insurance (DOBI), Division of Insurance colleagues in the development of policy and procedure; i.e., Grace's Law, EIS, and Autism. Likewise, DOBI partners participate with SCHEIS in provider and consumer education and advocacy and regularly provide technical assistance and training at the SCHS quarterly meetings. State SCHEIS staffs are dialoguing with DOBI staff in planning for NJ implementation of the Patient Protection and Affordable Care Act (PPACA).

The Department of Children and Families (DCF) is focused on strengthening families and achieving safety, well-being, and permanency for all NJ's children. Current priorities focus on child welfare, safety, health, family strengthening, and the establishment of foster homes. DCF is also engaged in reengineering child abuse prevention, building capacity in the child behavioral health system, and improving the system of health care for children in the State's care. Collaboration between State SCHEIS, local agencies implementing CYSHCN health and related support services, and the statewide DCF system are ongoing to ensure access to health and related services to the most vulnerable CYSHCN.

/2013/ In addition to routine dialogue to ensure access to supports as needed for CYSHCN with behavioral needs, Specialized Pediatrics staff organized a structured meeting with DCF. Key staffs from both Departments explored resources and linkages to better support clients through the DHSS' Child Evaluation Centers, Fetal Alcohol Spectrum and Alcohol-Related Neurodevelopmental Disorder and Autism Clinical Enhancement Centers, and DCF's Children's System of Care Initiative. The shortage of pediatric psychiatrists and improved access to psychology, counseling and family supports remain challenges in NJ, particularly in some of the more rural areas with limited transportation. //2013//

/2013/ Title V CYSCHCN is a partner with SPAN and AAP in SPAN's recent grant awards from the Healthcare Foundation of NJ and the Partners for Health Foundation, to connect primary care providers with child and adolescent psychiatrists, through the Essex County Primary Care-Child Psychiatrist Consultation Pilot Project.//2013//

Linkages with the DCF's Division of Prevention and Community Partnerships, Division of Community Services, and Office of Education ensures access to behavioral health providers, emergency response providers, the DCF child health nurses, and local child protection services offices. These linkages are essential for SCHS Case Managers, Specialized Pediatric Services (SPS) provider agencies, Ryan White Part D (RWPD) providers, EIS, and other DHSS programs to maintain capacity to serve the State's most vulnerable children.

Collaboration with the Department of Labor and Workforce Development ensures access to programs such as Vocational Rehabilitation, Social Security Disability Determination, Temporary Disability Insurance, and Workers Compensation. The Division of Vocational Rehabilitation (DVR) Services is responsible for training and placement of persons of employable age with disabilities. As SCHEIS counsels families on transition to adulthood planning options, programs regularly refer to DVR. Likewise, DVR staffs collaborate with SCHEIS programs on family and provider training, individual service plan, and individualized education plan development.

Medically fragile children from birth-6 years of age in need of day care services are typically referred by SCHS CMUs, SCHEIS specialty providers, EIS, primary care providers, and/or self referred to pediatric medical daycare providers. Community level collaboration is encouraged between pediatric medical daycares and SCHEIS to ensure that children are linked to health services and support services beyond childcare. Likewise, the State SCHEIS and DHSS Division of Support Services for the Aged and Disabled collaborate on ensuring access to pediatric medical daycare through technical assistance and training of community-based providers and rule making.

/2013/ Family Centered Care Services (FCCS) health services grantees continue to refer children to pediatric and/or adult medical day services and assist families as needed. In 2011, the DHSS and DHS announced significant revisions to the process of eligibility determination for medical day services. Some functions formerly conducted by DHSS staff have been restructured and the Medicaid HMOs have a more prominent role in the eligibility and plan approval process. Title V and DHS Medicaid disseminated information to FCCS grantees to facilitate these changes.//2013//

Childcare is a need for CYSHCN and SCHEIS collaborates with MAPS to Inclusive Child Care Training and Technical Assistance Project, Healthy Start programs, as well as the MCCH Adolescent Health unit. The goals of the project are to increase the quality of early care and education for children with special needs; increase the number of child care providers that offer inclusive child care; increase awareness among parents, child care providers ,and child care resource and referral agencies of the services available for children with special needs; and improve the delivery of services for children with special needs through collaboration among providers of child care services and special needs services.

Disaster/emergency preparedness for CYSHCN and their families requires community level collaboration. During an emergency, the government and other agencies may not be able to meet all residents' needs, and families of CYSHCN require additional special considerations to be prepared. In addition to the technical assistance and counseling on community resources and supports provided by SCHS CMUs and specialty providers, families of CYSHCN may register with the NJ Special Needs Registry for Disasters. The SCHEIS State office and SCHS CMUs collaborate with State Office of Emergency Management and local emergency and/or disability agencies coordinating voluntary registration with the Registry.
/2012/ State Office of Emergency Management periodically issues a newsletter targeting resources and services to support special populations in emergency planning. Collaboration on a joint article to support families of CYSHCN is in development for release in Spring/Summer 2011.//2012//

Housed in the DHSS, FHS, the NJ Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental nutritious foods to pregnant, breastfeeding and postpartum women, infants and children up to the age of five. Upon intake, SCHS CM and Specialized Pediatric Services Programs screen clients' needs and refer to WIC accordingly. Some SCHEIS providers are co-located with WIC sites which facilitates ease in referral. WIC services include supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. The Tertiary Centers and Cleft Lip/Palate Craniofacial Anomalies Centers consult with local WIC providers to facilitate access to formulas.

/2012/ State-wide training on Title V services for CYSHCN and how local WIC agencies could refer their clients was presented in 2010. Approximately 40 WIC providers participated. Referral of clients between WIC and Title V is facilitated by collaboration at the State office as well as at the local level. Common areas of collaboration include ensuring access to specialized formulas for infants, assistance with access to pediatric specialty and subspecialty care, as well as SCHS CM and Early Intervention Services.//2012//

/2013/ Despite legislation mandating coverage of special formulas, third party payment and Medicaid managed care authorization for compounded formulas and those required for allergies remain a challenge. To that end, State WIC staffs conducted a webinar hosted by Title V State staffs to educate SCHS CMUs, SPSP providers and SPAN Resource Specialists about its services, formula's and supports. In addition, an Abbott Nutrition representative participated in the webinar, discussing specialized formulas available through that company as well as their Patient Assistance Foundation.//2013//

Linkage with access to primary care is coordinated with NJs Office of Primary Health and the local Centers for Primary Health Care. These Centers refer CYSCHN to the SCHS Specialized Pediatric Service providers as well as to the SCHS CMUs for assistance in coordination. The Centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare and private insurance. If uninsured, family's bills are based on their ability to pay. No one is ever turned away for lack of funds.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 – Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010
Annual Indicator	47.7	50.2	49.2	43.5		
Numerator	2,687	2801	2741	2424		
Denominator	563,690	577,980	556673	557421		
Is the Data Provisional or Final?			Provisional	Provisional		

Notes – Source: Hospital Discharge Records from the NJ DHSS Health Care Financing Systems. Hospital discharge records count unique hospital stays for children not unique children hospitalized.

Narrative:
Asthma is the most common chronic disease reported in children. It is a leading cause of hospital stays and school absences and poses significant limitations on quality of life for many children and families. Asthma prevalence has increased worldwide in recent years. This trend has been linked to environmental factors, including air pollution. However, it is important to understand that indoor triggers can play just as much of a role as outdoor triggers in bringing on an asthma attack. The importance of access to consistent, quality health care cannot be overlooked in the attempt to reduce the burden of pediatric asthma. The rate of pediatric asthma hospitalizations appears to be decreasing in recent years most likely due to improvements in the chronic care management of children with asthma.

The DHSS Asthma Awareness and Education Program (AAEP) funds the American Lung Association of MidAltantic (ALAMid), to support the infrastructure of the Pediatric/Adult Asthma Coalition of NJ. The PACNJ implements strategies and initiatives to address the asthma burden, and assist the Department in implementing the State Asthma Strategic Plan. With over 70 members on six task forces, PACNJ works with schools, child care providers, health care providers, health insurers, community groups and environmental agencies to reach all individuals in NJ with the most effective methods for managing their asthma. PACNJ maintains 76 task forces including: Quality Care, Physician, Community, Schools, Child Care, Environment, and Evaluation. The 76 task forces are an integral component to PACNJ's success. The task forces meet to identify, review and design the various objectives and interventions. With the support of staff and resources from PACNJ and its member organizations, the task forces design and implement the various strategies/activities identified in the implementation plan.

The Asthma Coordinator and Epidemiologist for FHS serves on the PACNJ Coordinating Committee. Other state staff, particularly those on the State Asthma Committee, attend PACNJ meetings and participate in activities. The AAEP staff serves as liaison to facilitate collaborations with various internal and external stakeholders to ensure the implementation and accomplishment of PACNJ's initiatives.

The AAEP has collaborated with the NJDHSS Office of Minority and Multicultural Health (OMMH) in funding two community-based organizations to implement the Community Health Mobilization Grant Reducing Pediatric Asthma Disparities in Camden and Trenton for the 2011-2014 grant period. The project focus is to reduce pediatric emergency department visits and school absences for asthma in minority communities by reducing exposure to asthma triggers and by improving ability to self-manage asthma symptoms, through: 1) collaboration, 2) outreach, 3) identification and linkage 4) case management, 5) education and 6) evaluation.

Health Systems Capacity Indicator 02: *The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Indicator	94.7%		90.5%	92%	100%	97%	
Numerator	35,668		36166	36639	43,135	29,529	
Denominator	37,646		39971	39805	43,135	30,568	
Is the Data Provisional or Final?	Final		Final	Final	Final	Final	

Notes – Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 1/6/2012.

Narrative:
Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive preventive child health services to all Medicaid eligible children under age 21 including periodic physical, hearing, vision and developmental screenings. Identifying physical and developmental issues through screening of infants can significantly affect early child development and school readiness.

Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid. The performance on this indicator has improved greatly and according to the 2009 Annual EPSDT Participation Report (Form CMS-416), all infants enrolled in Medicaid receive at least one periodic screening. This high performance on the indicator is supported by the large increase in the total number of screens received by infants (151,834 during 2009) also reported on the 2009 Annual EPSDT Participation Report.

One of the major focuses of the Childhood Lead Poisoning Prevention Projects (CLPPP) is to promote proper use of preventive health services by the families of children who are lead burdened and at high risk of preventable health and developmental problems. CLPPP nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or NJ FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are CLPPPs in 12 communities.

Health Systems Capacity Indicator 03: *The percent of State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Indicator	N/A	N/A	90.5	92	100	97%	
Numerator	N/A	N/A	36166	36639	43,135	29,529	
Denominator	N/A	N/A	39971	39805	43,135	30,568	
Is the Data Provisional or Final?			Provisional	Provisional	Provisional	Provisional	

Notes – Data for HSCI #3 is currently not available. An estimate of the indicator using the percentage of period screenings for all NJ FamilyCare enrollees under age 1 is available from the Annual EPSDT Participation Report.

Narrative:
New Jersey FamilyCare is New Jersey's SCHIP. The Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services (DHS) administers NJ FamilyCare and the Medicaid Program. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in

EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare. Data for this indicator have been requested from DMAHS, but are not available. Data for Medicaid enrolled infants is provided as an estimate considering that the same Medicaid HMO plans cover SCHIP enrolled infants with the same benefit package.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Indicator	65.3	65.3	65.0	64.8	66.0	67.7	
Numerator	72,085	72,675	72,506	70,714	70,635	69,820	
Denominator	110,364	111,727	110,168	109,198	106,566	103,199	
Is the Data Provisional or Final?			Final	Final	Final	Provisional	

Notes – Source Electronic Birth Certificate file.

Narrative:
Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy related complications and conditions. HSCI #4 measures the percent of mothers who have received appropriate prenatal care as measured by the Kotelchuck Index.

Many factors delay the initiation of early prenatal care, including unintended pregnancies, lack of awareness of a pregnancy and lack of insurance. Despite major expansions of health care access during the 1990s, one in five women giving birth in NJ in 2008 still failed to receive first trimester prenatal care. Mothers most likely to benefit from early prenatal care because of their higher risk of poor birth outcomes remain even less likely to receive it. Efforts to improve access to early prenatal care must also focus on women before they become pregnant through the promotion of preconception care and family planning services.

In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in New Jersey. The Task Force was comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force presented a report and recommendations to Commissioner Howard in July 2008. Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications for the Access to Prenatal Care Initiative was developed to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report.

The goal of the Access to Prenatal Care Initiative is to increase the rate of first trimester prenatal care in NJ to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities. Related goals include decreasing the rate of preterm births and low birth weight newborns and reducing infant mortality. Education of providers and consumers, linkages of women and their partners to a medical home, and increased availability of services for prenatal, preconception and interconception are additional goals of the initiative. Projects seeking funding should be able to produce measurable positive outcomes in increasing the number of women accessing early prenatal care and or increasing access for reproductive age women and their partner for preconception and interconception care. Nine projects were funded a variety of best practice models. The individual projects are described in Section IV.C. NPM #18.

/2013/ The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. The projects utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doulas will be in the third year of a three year grant project period. Beginning with the SFY2013, the Department is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life Course Model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence. Funding would come from reduction of infrastructure costs due to the MCHC mergers and reductions to grantees with extended vacancies of grant funded positions. In addition, the MIEC Home visiting projects complement the services provided in the Access to Prenatal Care initiative. //2013//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2005	matching data files	8.7	7.9	8.4

Notes - Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the Hospital Discharge files and Infant Death Certificate files. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files.

Narrative:

Low birthweight (LBW) is an important measure of a healthy birth outcome and is a major risk factor for future health conditions, disability, and death. Disparities in LBW are largely driven by persistent racial/ethnic and socio-economic disparities in LBW. Nationally the percentage of infants born LBW has increased for more than two decades. Factors that have contributed to this increase are: the increases in multiple births, which are more likely to result in LBW infants than singleton births (though singleton LBW has also increased); obstetric interventions such as induction of labor and cesarean delivery; infertility therapies; and delayed childbearing.

Based on the recommendations from the Prenatal Care Task Force funding was redirected to the Access to Prenatal Care Initiative to decrease the rate of LBW, preterm births and infant mortality and to increase access to prenatal care. Infant mortality reduction funding was redirected from Healthy Mothers, Healthy Babies Coalition outreach and education to the Access to Prenatal Care Initiative request for applications. The Access to Prenatal Care Initiative in addition to FIMR, Perinatal Addictions Prevention, Postpartum Mood Disorders initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The Fetal Alcohol Spectrum Disorders and Perinatal Addictions Prevention Projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period.

/2013/ The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need

areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. These projects are monitoring perinatal outcomes including birth weight.//2013//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births.*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2004	matching data files	7.6	6.5	6.7

Notes - Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the Hospital Discharge files and Infant Death Certificate files. Most recent year available is 2004. Calculated rates/percents may not match rates/percents from the official Death Certificate files.

Narrative:
Multiple factors contribute to the disparity in infant death rates between the Medicaid and non-Medicaid population. Preconceptual women's health, access to family planning services, access to early prenatal care, maternal medical risk factors, social and behavioral risk factors all contribute to the persistent disparities in infant mortality rates. The Prenatal Care Task Force Report contained recommendations for consideration and possible implementation to improve prenatal care and reduce infant mortality. The recommendations stressed many important goals such as increasing public awareness of preconception health, ensuring the availability of ongoing early prenatal care services, and promoting equity in birth outcomes. The Department through Reproductive and Perinatal Health Services issued a competitive request for application to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates, called the Access to Prenatal Care Initiative. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

The Access to Prenatal Care Initiative, FIMR, FASD, Perinatal Addictions, Post Partum Depression Initiative are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR Center is designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. MCHC conducts community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FASD and Perinatal Addictions projects (SP #1) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period.

/2013/ The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. These projects are monitoring perinatal outcomes including birth weight.//2013//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	matching data files	59.2	84.5	75.1

Notes - Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the Hospital Discharge files and Infant Death Certificate files. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files due to missing and unknown insurance type.

Narrative:
Improving access to first trimester prenatal care is essential to promoting the health of New Jersey mothers, infants, and families. Early prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy related complications and conditions. Access to prenatal care is extremely important; yet many factors delay the initiation of early prenatal care, including unintended pregnancies, lack of awareness of a pregnancy and lack of insurance.

According to New Jersey PRAMS survey data cited in the Commissioner's Prenatal Care Task Force Report, maternal demographics such as age, education and marital status affected first trimester prenatal care rates, but health insurance status during pregnancy had the stronger effect on first trimester prenatal care rates. Mothers who were privately insured were most likely to enter first trimester prenatal care for all age, education or marital status groups. Chances of first trimester prenatal care increased when the mothers were married, had at least a high school education and were at least 20-29 years old.

Mothers with continuous FamilyCare coverage, meaning they had FamilyCare coverage both before and during the pregnancy, had a first trimester prenatal care rate of 78%. New FamilyCare mothers, which include those who enrolled in FamilyCare during their pregnancy, had a first trimester prenatal care rate of 76%. Mothers with No Insurance during prenatal care had the lowest rate of first trimester prenatal care at 73%. Before pregnancy 21% of mothers, including 54% of FamilyCare mothers, had no health insurance and most likely lacked ongoing preventive health care before pregnancy.

Efforts to improve access to early prenatal care must address the factors related to unintended pregnancy and lack of early pregnancy awareness by focusing on women before they become pregnant. Preconception care is a critical component of prenatal care and health care for all women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care. Policies to promote family planning are a priority not only because they reduce unintended pregnancies, but also because they can improve the initiation of early prenatal care.

The Prenatal Care Task Force Final report contained recommendations to improve first trimester prenatal care. The recommendations of the Task Force and the implementation of the Access to Prenatal Care Initiate by Reproductive and Perinatal Health Services has been described in the earlier sections on HSCI #4, 5A and 5B.

/2013/ The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. The projects utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doulas will be in the third year of a three year grant project period. Beginning with the SFY2013, the Department is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence. Funding would come from reduction of infrastructure costs due to the MCHC mergers and reductions to grantees with extended vacancies of grant funded positions. In addition, the MIEC Home Visiting projects complement the services provided in the Access to Prenatal Care initiative.//2013//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	matching data files	45.9	71	62.2

Notes - Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to official Birth Certificate files. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files. Slight difference between HSCI 04 due to restricted age group (15 to 44).

Narrative:

Adequate as well as early prenatal care is important in helping to prevent poor birth outcomes such as preterm labor and birth, low birth weight and infant mortality. In addition to improving maternal health and birth outcomes, early and adequate prenatal care promotes preventive care for young children. The disparity in access to early and adequate prenatal care has been a focus for FHS. The Prenatal Care Task Force report contained specific recommendations addressing issues related to Medicaid coverage and barriers to women initiating early prenatal care, especially in areas affected by hospital closures or reductions in obstetric services. Efforts to address disparities in prenatal care utilization by FHS through the Access to Prenatal Care Initiative have been described in earlier sections on HSCI #4, 5A, 5B and 5C.

/2013/ The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. The projects utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doulas will be in the third year of a three year grant project period. Beginning with the SFY2013, the Department is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. In addition, the MIEC Home Visiting projects complement the services provided in the Access to Prenatal Care initiative.//2013//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2012	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2012	350

Narrative:
The Medicaid Program in New Jersey is located in the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services. DMAHS also administers the SCHIP program. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid maternity services. A child born to a woman eligible for and receiving Medicaid is guaranteed eligibility for one year. The comprehensive services include medical care, case coordination, health education and psychological services. Income eligibility levels for NJ FamilyCare by child age and family size are available at http://www.njfamilycare.org/pages/whatItCosts.html

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children.*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 0 to 1) (Age range 1 to 5) (Age range 6 to 19)	2012	 185 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18)	2012	 350

Narrative:
The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women and children with incomes below 185% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for infants and children 1 to 18 is 350%. Income eligibility levels for NJ FamilyCare by child age and family size are available at http://www.njfamilycare.org/pages/whatItCosts.html .

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women.*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2012	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2012	350

Narrative:
The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for pregnant women is 350%. Income eligibility levels for NJ FamilyCare by child age and family size are available at http://www.njfamilycare.org/pages/whatItCosts.html .and http://www.nj.gov/humanservices/dmahs/clients/medicaid/pregnant/index.html

Several initiatives including Healthy Mothers/Healthy Babies and Healthy Start promote the early enrollment and full participation in the Medicaid and SCHIP Programs.
/2013/ The Access to Prenatal Care Initiative, Healthy Start and MIEC HV projects all promote the early enrollment and participation in the Medicaid programs.//2013//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Indicator	59.4%	61.8%	56.0%	59.0%	62.0%	
Numerator	317312	335797	338979	378,982	384,652	
Denominator	534469	542985	605041	642,519	620,109	
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	

Notes – Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 1/6/2012.

The need for health insurance among children in NJ is great and may be growing as a result of the current economic downturn. Providing services to all potentially Medicaid-eligible children is a challenge that requires the timely identification of uninsured children and will require the collaborative efforts of multiple state departments.

Many families are not aware of the availability of free or low cost health insurance programs. Others are overwhelmed by the requirements and information necessary for the enrollment and renewal processes or are unable to pay required monthly premiums and either never enroll or drop off the rolls each month despite being eligible for Medicaid or NJ FamilyCare. Many reasons are cited as barriers to enrollment

and retention including: language barriers, concerns regarding immigration status, financial hardships, mistrust of government programs and inability to meet documentation requirements.

The NJ Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

Recent changes in federal law give states new opportunities to streamline procedures for enrolling children in health insurance programs and improving the efficiency and effectiveness of enrollment and retention practices. NJ is the first state to take advantage of these new opportunities and is in the midst of executing an unprecedented direct outreach campaign. NJ developed an Express application for enrolling children in NJ FamilyCare and Medicaid and is mailing it to the households of the nearly 360,000 children who were identified as uninsured on state tax returns.

Based on the Work Group's research and discussion, barriers and recommendations were identified. A report, NJ FamilyCare Outreach, Enrollment and Retention Report May 2009, was produced which identifies findings and recommendations to help meet goals of the Reform Act.

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed, in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward. Federal health insurance reforms and expansion of Medicaid and SCHIP will also positively impact children and families in need of health care services.

/2013/ NJ has one of the nation's most generous health insurance programs for low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare Advantage, A family of four earning up to $77,175 is eligible to apply. There is no cost for many families and for those with higher incomes, there is a sliding scale for small co-payments and monthly premiums. For families who earn too much to qualify for NJ FamilyCare, NJ offers NJ FamilyCare Advantage (visit www.horizonNJhealth.com. NJ has simplified enrollment and renewal and reduced paperwork with the use of an express lane application. New Jersey's schools, hospitals, state officials and community agencies have been working together to enroll more children who are eligible to be insured.//2013//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Indicator	33.3	39.9	43.7	44.6	51.8	58.7	
Numerator	36,065	41,222	51,042	53,714	66,437	76,696	
Denominator	108,419	103,251	116,822	120,383	128,294	130,568	
Is the Data Provisional or Final?	Final	Final	Final	Final	Final		

Notes – Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services FY 2010 report dated 1/6/2012.

Narrative:

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive preventive child health services to all Medicaid eligible children under age 21 including periodic physical exams; hearing, vision and developmental screenings; lead poisoning screening; vaccines; health education; and dental inspections and referrals. Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid. The performance on this indicator has improved greatly and according to the 2009 Annual EPSDT Participation Report. A total of 66,437 (51.8%) eligible children ages 6 to 9 years old received dental services during 2009 out of 128,294 children eligible for EPSDT services.

/2013/ Dental initiatives undertaken by DMAHS to promote utilization of dental services:

Oral Health Stuffer – "Keeping Your Child's Smile Healthy" was updated in 2012 to indicate age referral to dentist should occur by the age of 1. Language was revised to provide information in layman terms while educating the consumer on dental terms. Stuffer is provided in mailings to those in Fee For Service (FFS), was provided to HMOs for distribution to their members and to WIC for distribution to their clients. It is posted on the Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) and on the websites for American Academy of Pediatricians and Center for Health Care Strategies.

Dental Advisory Council - meets three times a year, but is also convened for special projects. The council was established in 2005 by the Division of Medical Assistance and Health Services (DMAHS) and works to bolster communication with the dental community and has representation from the NJFC HMOs, UMDNJ – Dental School, Federally Qualified Health Centers, NJ State Board of Dentistry, NJ Dental Association, the dental specialties and dentists from private offices. The Council's activities may include study of priorities, standard of care, quality measures, barriers to care and access strategies, utilization strategies, program benefits and cost of care. The council prepares specific recommendations to DMAHS and interprets goals and policies for professional and community interest groups.

Medical/Dental Directors Meetings – These meetings occur two to three times a year and are a forum to allow DMAHS to communicate directly with the medical and dental directors for the NJFC-MCOs on interpretations, expectations or revisions to policies as set forth in New Jersey Administrative Code (N.J.A.C.) or the HMO Contract.

The Periodicity of Dental Services for Children in the NJFC Programs titled "When Children in NJ Family/Care Should See the Dentist" was revised in 2012 to be consumer friendly. It was updated to indicate referral to a dentist is required by age one, that a trained medical professional could also provide fluoride varnish and emphasized that needed dental treatment should be provided to primary or "baby" and permanent teeth. This information is posted on the Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) and on the websites for American Academy of Pediatricians and Center for Health Care Strategies.

Oral Health Stuffer – "Keeping Your Child's Smile Healthy" is informational on what a caregiver can do to keep a child's smile healthy beginning with the eruption of the first tooth. The goal is educate families that you cannot have good overall health without good oral health and encourages them to establish a dental home early in a child's life so that they can begin preventive dental services and learn good oral health habits at a young age.

NJ Smiles Directory of Dentist Seeing Young Children – this directory is a listing by county of dentists seeing young children. It includes their HMO or Fee for Service participation, if they are handicapped accessible and if they provide dental care to patients with special healthcare needs. It is also available as fact sheet by county with this version having the periodicity table and oral health educational materials included. It is updated annually and will be posted on the

Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) and is currently on the websites for American Academy of Pediatricians and Center for Health Care Strategies.

Insure Kids Now Website – Information on the dental benefits available to children enrolled with NJFC/Medicaid is posted on this site along with the names and contact information for dentist seeing children by HMO and State Fee for Service.

Age for First Dental Visit – Contract change for NJFC MCOs effective July 1, 2010 indicates that first dental visit can be provided as early as the eruption of the first tooth and is required by age one.
Preventive Services by Non-Dental Health Care Providers – Contract change for NJFC MCOs effective January 1, 2012 allows a trained medical professional to provide risk assessment, fluoride varnish and direct referral to the dentist for young children through the age of five.

American Academy of Pediatricians (AAP) Oral Health Initiative – DMAHS has partnered with the AAP on this initiative to identify and establish strategies to educate medical providers on the importance of early intervention with an age one dental visit, oral health education, fluoride varnish, risk assessment and dental referral, to educate parents and communities on the importance of good oral health, healthy habits, the need for early and periodic dental visit and treatment and to identify and develop financial strategies to providers for use by payers of services.

Give Kids A Smile – Each year DMAHS collaborates with the NJ Dental Association to provide volunteers that assist families with NJFC/Medicaid in locating a dentist and to provide enrollment information or location of clinics for those without dental insurance.//2013//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Indicator	60.0	60.0	58.4	59.7	54%	50%	50%
Numerator	4,800	4,500	4,500	4,600	7,348	4,805	2,879**
Denominator	8,000	7,500	7,700	7,700	13,810	13,649	15,324
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Provisional	Provisional

Notes – * In 2009 an efficiency was implemented to support computerized access to the monthly SSI reports and actual unduplicated data reflected.
**In 2011, Denominator reflects actual unduplicated SSA referrals. Numerator includes population served across Family Centered Care Services (FCCS) grantees identified as SSI beneficiaries.

Narrative:
In accordance with the charge to ensure that Supplemental Security Income (SSI) beneficiaries less than 16 years old receive rehabilitation services, SCHEIS links each CYSHCN referred by the Social Security Administration to their SCHS Case Management Unit for follow-up. From point of referral, outreach is conducted by a county SCHS Case Manager (registered nurse/social worker). Intake is offered and provided accordingly. Needs are identified with the parent/guardian. The case manager provides information on local, State and/or federal resources including referral to rehabilitative services, pediatric specialty, medical home, family support and other services as needed. For example, clinical services may be provided through the Specialized Pediatric Services providers; Child Evaluation Centers, Cleft Lip/Palate Centers and Tertiary Care Centers, and/or family support. With family input the SCHS Case manager develops an individualized service plan (ISP) based on the child's needs. Goals are determined with the parent/guardian, monitoring dates are planned, follow-up is conducted and outcomes are measured. Assistance to linkage with services is offered and provided as needed.

In 2009, the monthly SSI report was revised from a paper report to a web based format and it is accessed online through the NJ State portal. County specific reports of active, terminated and expired status are password protected and viewable only to State staffs and the SCHS Case Management Units in the county in which the child resides. The efficiency of shifting to electronic reporting and referral afforded SCHEIS more accurate reporting; 13,810 CYSHCN referred in 2009 versus 7,700 in 2008 (80% increase in total unduplicated referrals); and 7,348 CYSHCN served in 2009 versus 4,600 in 2008, (60% increase in unduplicated served). In 2009, 22% (2,350) of the 10,500 active children (with ISP's) served statewide through the County Case Management Units were identified as SSI beneficiaries.
/2012/ Subsequent to implementation of the web based SSA referral system, the State Case Management program implemented a quality assurance initiative. Three SCHS Case Management Units (CMU's) were randomly selected and audited by State staffs to determine compliance with follow-up on electronic referrals. Of those 3, 100% were noted to have designated staff initiating follow-up contacts with families of CYSHCN referred via SSA within 21 days. Follow-up by SCHS CMU's included re-contacting CYSHCN known to the county SCHS CMU but with a revised SSA status to assess change in needs, outreach to new referrals and linkage with community-based resources. Additional benefits of this initiative included development of a procedure to guide SSA electronic referral follow-up, technical assistance to grantees and grantees reported reduced need for storage of paper records. The fluctuation in the number of children served in 2009 (7,348) as compared to 2010 (4,805) was attributed to the rapid increase in number of referrals received and outreached, secondary to the electronic transmission of referrals. Trends will continue to be monitored. Plans for the upcoming year include adding the SSA audit to the annual site visit and sharing successful follow-up strategies among SCHS CMU's. For example, initial follow-up is typically a telephone call to families. However, when telephone number is not provided by the referral, one SCHS CMU reported mailing a packet to families that included developmental specific information with the cover letter and county specific brochure. That same county reported a positive reaction to the mailing by families. //2012//

/2013/ Overall, in 2011, 13,649 total referrals were forwarded by the SSA to the SCHS CMUs; 7,600 active and 6,049 terminated. Although 100% new referrals are matched to the SCHS CM case load and receive a contact from SCHS CM, the 2011 numerator data reflects children on SSI that received "services" by NJ Title V programs; SCHS CM or a service encounter by a Specialized Pediatric Services provider. The State staffs' site visit procedure for onsite audits at the SCHS CMUs was revised in 2011 to capture the CMUs' ability to access SSA referrals and process them in a timely manner. In 2011, 100% of the SCHS CMU staffs had access to the electronic referral system and were using it as required. Two CMUs had experienced recent staff turnover and requested additional training. A designated State SCHEIS staff person provides telephone technical assistance on the SSA referral system and she will participate in the upcoming regularly scheduled site visit to revisit those agencies to ensure compliance. In addition, using input from the SCHS CMU Coordinators a need for training on the SSI application process and eligibility determination was determined. State staffs are planning a statewide update on the SSI application to be conducted during a regularly scheduled quarterly 2012 SCHS CMU meeting, inviting co-presenters from the NJ Department of Labor Disability Determinations Unit and a NJ SSA office.//2013//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Narrative:
The goals of the State Systems Development Initiative (SSDI) grant within the MCH Epidemiology Program focus on for building data capacity in MCH (Health Status Indicator (CHSI) #9A). The goals of the grant are improving linkages of MCH datasets and improving access to MCH related information. Linking MCH related datasets is important to the needs assessment process for communities and the evaluation of program services. Assuring access of FHS to MCH related datasets is important to improving the reporting of Title V MCH Block Grant Performance/Outcome Measures and to improving the delivery of services to the MCH population. Examples of efforts to utilize MCH data include the Commissioner's Prenatal Care Task Force and the Population Perinatal Risk Index.

Our vital statistics files, Medicaid files and programmatic data files all provide some information about the status of health in the MCH population and the effectiveness of MCH programs. However, no file alone provides the full picture of what happens to pregnant women, infants and children. In order to accurately assess the continuum of events that lead to favorable or unfavorable outcomes, files and information systems must be linked.

The MCH Epi Program has been able to both link records across files and longitudinally across health care related events in a mother's life. A combined dataset was created for the years 1996 through 2006 containing the electronic birth certificate, mother and newborn hospital discharge records, and infant death certificates for all NJ births. Data from this dataset are used to support research projects that focus on welfare reform and immigrant health, foreign-born mothers and issues related to health disparities, and maternal mortality review in New Jersey.

Asthma-related hospital discharge data have been longitudinally linked to create a wealth of information surrounding hospitalizations for children with asthma. This dataset is being used to enhance our asthma surveillance system as well as examine issues related to repeat admissions, and asthma severity.

The MCH Epidemiology Program with CDC funding has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey in collaboration with the Bloustein Center for Survey Research at Rutgers University. Data from this survey will be used to identify high-risk pregnancy groups

and to target programmatic interventions. Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants. NJ PRAMS briefs on a variety of topics are available at the NJ PRAMS website - http://nj.gov/health/fhs/professional/prams.shtml

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
New Jersey Youth Tobacco Survey	3	No

Narrative:
Adolescent smoking and smokeless tobacco use are the first steps in a preventable public health tragedy. Adolescent users become adult users, and few people begin to use tobacco after age 18. Preventing young people from starting to use tobacco is the key to reducing the death and disease caused by tobacco use. Current cigarette among NJ high school students declined sharply during 1997–2003; however, rates have remained relatively stable over the past several years.

According to the NJ Youth Tobacco Survey (NJYTS), the percentage of all NJ high school students who reported ever using tobacco (**lifetime** tobacco use) decreased from 53.9% in 2004 to 44.5% in 2010.

Further, similar trends are noted for **current** cigarette smoking for high school students. The NJYTS found current smoking among NJ high school students to be 24.5% in 2001, 15.8% in 2006, 14.3% in 2008 and 14.3% in 2010. Consistent with the NJYTS findings, data from the YRBS also demonstrate a leveling off of current cigarette use among all U.S. high school students between 2003 and 2007.

An effective strategy to reduce youth smoking prevalence and consumption is to increase the unit price for tobacco by raising the product's excise tax. According to a report from the NJDHSS Office of Comprehensive Tobacco Control Program), the overall decline in youth cigarette consumption in New Jersey reflects, in part, the effects of large increases in the State's cigarette excise tax. New Jersey increased the cigarette excise tax four times in as many years and currently ranks as one of the highest cigarette excise tax among all US states. Higher cigarette taxes generally reduce smoking prevalence and consumption, while increasing tax revenue.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs.

However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco caused disease, death and disability.

Finally, consistent funding for youth prevention must continue. There is evidence that higher state-level tobacco control funding is associated with lower youth smoking prevalence and cigarette consumption. Despite the considerable success achieved in New Jersey, funding for comprehensive tobacco control was eliminated in 2010. The Comprehensive Tobacco Control Program was downsized into the Office of Tobacco Control (OTC) on July, 2010.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 Maternal Child Health Bureau (MCHB) has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section describes the performance reporting requirements of the Federal-State partnership. Figure 3, "Title V Block Grant Performance Measurement System" on page 45 of the federal guidance, presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five-year statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities, as measured by 18 National performances measures and State performance measures should have a collective contributory effect to positively impact a set of 6 national outcome measures for the Title V population.

B. State Priorities.

This section describes the relationship of the priority needs, the National and State performance measures, and the capacity and resource capacity of the State Title V program.

SP #1. Increasing Healthy Births

Increasing Healthy Births is a state priority that encompasses reducing low birth weight, preterm births, infant mortality, and increasing first trimester prenatal care and adequate prenatal care (NPM #8, 15, 17, 18). Several initiatives address healthy births including Healthy Mothers, Healthy Babies Coalition outreach activities, Healthy Start outreach activities, Community Action Team projects based on FIMR findings, and most recently the Access to Prenatal Care Initiative. The Perinatal Addictions Prevention projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period. Preconceptual health projects seek to have a healthy mother prior to conception.

The Family Planning projects provide a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services and services for adolescents. Clinics have effective contraceptive methods, breast and cervical cancer screening, nutrition and prevention services that correspond with nationally recognized standards of care, sexually transmitted infections (STIs) and HIV prevention education, testing and referral, adolescent abstinence counseling, and other preventive health services. Aimed at schools and community groups, educational activities focus on primary pregnancy prevention, the program integrates assessment of adolescent risk behavior within routine family planning services.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout NJ to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents.

/2013/ The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Access to Prenatal Care Initiative. Beginning with the SFY2013,

RPHS is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence.

The 12th Annual Adolescent Health Institute was held in November 2011 and the 13th is planned for November 16, 2012.//2013//

SP #2. Improving Nutrition and Physical Activity

Improving Nutrition and Physical Activity is a state priority related to SPM # 4 and NPM #14 and the growing obesity epidemic in NJ and nationally. NJ has one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer.
/2012/ According to 2009 PedNSS data of 2-5 year old WIC children, 35.9% were obese (18.4%) or overweight (17.5%).//2012//

In May 2008 DHSS was awarded a 5-year cooperative agreement by the CDC to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement ONF has taken the lead in building a robust infrastructure by creating a statewide partnership of organizations and individuals, called ShapingNJ, to collaborate, build capacity and develop a comprehensive and coordinated system to halt further increases in obesity and other chronic diseases. Activities of the ONF and the ShapingNJ partnership are discussed in detail in the section on NPM #14 and SPM #4.
/2012/ The ShapingNJ Partnership is comprised of more than 100 organization members who have signed a partner agreement with Shaping NJ to collaborate on addressing nutrition, physical activity and obesity (NPAO) prevention strategies in five (5) settings: schools, communities, child care centers, worksites and healthcare facilities.//2012//

/2013/ NJ has one of the highest obesity rates among low-income children 2 to 5 years of age at 17.3 percent in 2010. ShapingNJ is the statewide partnership of 185 organizations.

In 2011-2012, the DOE CSH provided technical assistance and developed a Student Focus Group Toolkit. This toolkit enabled wellness team leaders to conduct focus groups to gain insight into student eating and activity behaviors before and after school. The focus group data resulted in more student participation in planning of school events. The Student Focus Group Toolkit was also provided to DHSS CSH grantees. In addition, DOE conducted Fitnessgram and SHI trainings to DHSS CSH to assure alignment between the departments.//2013//

SP #3. Reducing Black Infant Mortality

Maternal and Child Health Services (MCHS) has a long history of interest in perinatal health disparities with special emphasis in 1985 when the Infant Mortality Reduction Initiative was initiated. Subsequently, MCHS submitted an application for the initial round of Healthy Start projects. In 1996, the Department established the Blue Ribbon Panel on Black Infant Mortality Reduction. Following release of the report from the panel, an Advisory Panel on Black Infant Mortality was created to implement recommendations from the report including a public awareness campaign and community-based projects to provide outreach and education services in high need communities.

The Northern NJ MCH Consortium has been funded to serve as the Black Infant Mortality Reduction (BIMR) Resource Center under the BIMR Initiative since 1999. The Center acts as a clearinghouse,

providing literature, statistics, and other information on BIMR.

Following recommendations from Commissioner Heather Howard's Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities are described for SPM #1.

/2013/ The Access to Prenatal Care initiative addresses eliminating disparities in all of its activities. The grantees target the areas that have had the poorest birth outcomes and lowest rates of first trimester prenatal care.//2013//

SP #4. Reduction of Adolescent Risk Taking Behaviors

Creating a Coordinated School Health (CSH) System in NJ to reduce adolescent risk taking behaviors relates to NPM #8, 10, 13, 16 and SPM #5 &, 6 & 10. The anticipated start date of this project is July 1, 2010. The current DHSS Community Partnerships for Healthy Adolescents (CPHA) initiative, will end with the start-up of the three regional CSH grants. The CPHA initiative conducted a total of 220 activities impacting 51,624 adolescents and addressed these issues: violence prevention including bullying and gangs, improving healthy food choices, increasing physical activity and decreasing TV and other screen time; access to youth-serving health and social services; alcohol, tobacco and other drugs (ATOD), sexuality and prevention of sexually transmitted infections (STIs) including HIV/AIDS, life skill development and heart health.
/2012/ The CPHA initiative ended June 30, 2010. The CSH System in NJ began on schedule on July 1, 2010.//2012//

/2013/ CSH grantees and their school partners are implementing activities to create a culture of health and wellness through the use of school health wellness teams, improvements to strengthen local school health policies (mainly through physical activity, nutrition and tobacco (PANT) strategies and by assessing school climate through participation in Rutgers University's Improving School Climate for Academic Success (ISCALS) survey. In September 2011, schools were required to implement the Anti-Bullying Bill of Rights. This law, touted to be the toughest in the country, set new rules and strict time frames for schools to address alleged harassment, intimidation and bullying (HIB) and required schools to designate an anti-bullying specialist and create a school climate team. In March 2012, the legislature approved a $1M appropriation to fund the changes required by the law.//2013//

In 2009 a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco. Three grants, each located in one of three NJ regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's Coordinated School Health model in at least eight public middle- and/or high- schools of public school districts.
/2012/ Three regional grantees and one individual grantee were awarded funds to work with a total of 28 school partners in 1/3 (7 counties) of New Jersey.//2012//

SP #5. Improving Access to Quality Care for CYSHCN

NJ will continue to improve access to quality care for CYSHCN through collaboration and partnership building, targeting resources and efforts to maintain capacity and to comprehensively address the six

MCHB core outcomes for CYSHCN and State Performance Measures (#6, 7, and 8) in order to achieve its State Priority # 5 of Improving Access to Quality Care for CYSHCN.

The network of specialty providers, linkages with enabling services provided by Special Child Health Services Case Management Units (CMUs), collaboration with intergovernmental agencies and community-based organizations (refer to stakeholder list), and leadership from the State agency strengthens the safety net of access to care for NJ's CYSHCN. Although many of NJ's CYSHCN have access to primary care, the coordination of care for medically fragile children is often managed through their specialty providers; Child Evaluation Centers (CECs), Fetal Alcohol Syndrome/and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers, Cleft Lip/Palate Craniofacial Anomalies Centers, Tertiary Care Centers and Ryan White Part D HIV Care Network, and NJ is attempting to reverse that trend. Through the NJ Academy of Pediatrics' Pediatric Council on Research and Education's (PCORE) efforts to promote medical home and the Statewide Parent Advocacy Network's (SPAN's) statewide Systems Integration Grant (SIG)
/2012/ State Implementation Grant for Integrated Community Systems (Integrated Systems Grant or ISG 1) activities, medical home initiatives are being developed to promote collaboration between pediatric subspecialists and primary care providers. NJ is working toward all CYSHCN receiving high quality, comprehensive care through a medical home that assures timely access to necessary pediatric specialty and subspecialty care, community supports, and transition to adult care when appropriate. //2012//

/2013/ Title V efforts to improve quality of care included continued collaboration on ISG 1 and ISG 2 addressing the six core outcomes for CYSHCN through parent-professional medical home initiatives. Using a multi-county approach, outreach was conducted to pediatric and family practices, and federally qualified health centers throughout the southern and central regions of the State. The SCHS CMUs provided lists of providers that routinely served CYSCHN in their case loads, and SPAN and PCORE invited practices to "Kick Off" events providing an overview of the medical home/ISG initiative. Title V provided consultation on specialized pediatric services and case management, presented at medical home learning collaborative meetings and care coordination webinars, and provided resources to practices. Additional outreach to the northern and western regions of NJ are scheduled into 2012.//2013//

NJ continues to work toward ensuring that a sufficient number of pediatric subspecialists are available statewide to provide high quality tertiary care to CYSHCN and endorses the interdisciplinary team approach to comprehensive care. In addition to autism care being provided by the CECs, 6 Clinical Autism Centers have been partially funded by the Governor's Council for Medical Research and Treatment of Autism/DHSS to enhance their autism diagnostic and treatment services.

Access to appliances including hearing aids, braces, orthotics; and medications for the treatment of asthma/cystic fibrosis is facilitated through the SCHEIS Fee for Service program.

Training and technical assistance for SCHS CMUs, Pediatric Specialty Providers, families and community-based partners on NJ's rapidly evolving health insurance landscape is critical in 2010 and for the near future. In 2008, the NJ Healthcare Reform Act expanded NJ FamilyCare, established a mandate for health care coverage of children, and reformed individual and small employer insurance markets. In addition, recently passed legislation requires State regulated insurance plans to cover certain treatments for autism and other developmental disabilities, including those treatments based on Applied Behavior Analysis. Full and equitable financing by NJ third party payers and State Medicaid remains a challenge but we embrace that challenge to achieve the early identification and management of chronic conditions, comprehensive preventive care, and collaborative practice between primary and subspecialty pediatric care. The landmark federal Patient Protection and Affordable Care Act contains some provisions that have already existed in the NJ individual and small employer markets. However, some provisions that affect children are to be implemented as of July 1, 2010, including plans may not exclude coverage for children under age 19 due to pre-existing conditions and plans may not establish lifetime limits on the dollar value of essential benefits, as well as other significant changes that affect access to care. Dialogue with colleagues in the NJ Department of Banking and Insurance, the SCHS CMUs, Pediatric Specialty

Care providers, SPAN's ISG 1 Consortia of Care, PCORE and other stakeholders described earlier will be important to maintain access to care in this changing environment, and community-based trainings on how these changes benefit CYSHCN will be addressed.

/2012/ In 2010, periodic training and updates on NJ's implementation of the federal Patient Protection and Affordable Care Act has been provided to the SCHS CMUs by the NJ Department of Banking and Insurance (DOBI). Likewise, DOBI regularly updates its website to provide consumers with access to healthcare changes. For example, in July 2010 NJ unveiled a new health insurance option for uninsured persons with pre-existing medical conditions. Coverage through NJ Protect will generally cost less than comparable individual health insurance. Because the program is federally subsidized, treatment for pre-existing medical conditions is covered as of the day a policy goes into effect, and preventive care will be covered at no out-of-pocket cost to the policyholder. The introduction of this new insurance product, in addition to existing programs such as NJ Medicaid, NJ FamilyCare, and NJ Advantage provides the uninsured with additional options to access affordable healthcare. However, families of CYSHCN report that challenges remain particularly in the private insurance sector, i.e., affordability of rising costs for co-payments and premiums; non-covered services such as private duty nursing and durable medical equipment; gaps in coverage of hearing aids for youth over age 15 years. Likewise, it remains a challenge for families and service providers to understand the rapidly evolving health insurance arena.//2012//

/2013/ A statewide teleconference featuring Ms. Tricia Brooks, senior fellow at the Center for Children and Families and an assistant research professor at the Georgetown University Health Policy Institute was conducted to educate State Title V staffs and FCCS grantees on anticipated changes in health care reform for 2014. The presentation format provided an opportunity to dialogue with a national expert on policy and implementation issues affecting coverage for children and families with a focus on children who are eligible but not enrolled in Medicaid and SCHIP.//2013//

Given the high rate of overweight and obesity in CYSHCN, SCHEIS, by joining Shaping NJ and collaborating with other stakeholders, is currently working to draw attention to the obesity prevention needs of CYSHCN.

SP #6. Reducing Teen Pregnancy

Teen pregnancy prevention is a state priority for NJ and relates to NPM #8 & SPM #4. Teenage childbearing can have long-term negative effects on both the teenage mother and the infant. Infants born to teen mothers are at higher risk of being low birthweight and preterm. They are also far more likely to be born into families with limited educational and economic resources. Several inter-agency initiatives have been developed to address this priority.

Title X, NJ Family planning agencies with 58 clinical sites continue to provide comprehensive reproductive health services to adolescents provided free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

/2012/ MCHS applied for and was approved for funding from DHHS, ACF: 1) Title V New Jersey Abstinence Education Project (AEP); and, 2) Personal Responsibility Education Program (PREP). A competitive AEP RFA was released in February 2011. Grant funding is expected to begin July 1, 2011. A competitive RFA for PREP was released in July 2011. Grant funding is expected to begin October 1, 2011.//2012//

/2013/ Grant funds for Title V AEP was awarded to four grantees, two in the northern region, one in central and the fourth in the southern region. The AEP has implemented activities since October 2011. PREP funds were awarded to seven grantees serving at least 50% youth in the 30 high-risk New Jersey municipalities. Implementation of PREP is planned for fall of 2012.

/2013/ Title X NJ Family Planning agencies provide services in all 21 counties through 49 sites.//2013//

SP #7. Decrease Asthma Hospitalizations

Asthma is the most common chronic disease reported in children. It is a leading cause of hospital stays and school absences and poses significant limitations on quality of life for many children and families. Asthma has increased in NJ and worldwide in recent years.

The DHSS Asthma Awareness and Education Program (AAEP) funds the American Lung Association of MidAltantic (ALAMid), to support the infrastructure of the Pediatric/Adult Asthma Coalition of NJ. The PACNJ implements strategies and initiatives to address the asthma burden, and assist the Department in implementing the State Asthma Strategic Plan. With over 70 members on six task forces, PACNJ works with schools, child care providers, health care providers, health insurers, community groups and environmental agencies to reach all individuals in NJ with the most effective methods for managing their asthma.

Significant accomplishments in the last year are detailed in the section for HSCI #1 (rate of children hospitalized for asthma).

SP #8. Improving and Integrating Information Systems

The MCH Epidemiology Program, Family Health Services and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to NPM #1, 9, 12 & HSCI #5, 9A, 9B, & 9C. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

The Electronic Birth Certificate (EBC) System is in the process of being upgraded to a web-based Electronic Birth Registry System (EBRS). The Bureau of Vital Statistics and Registration has involved staff from FHS and the MCH Consortia in the development of an RFP for the EBC upgrade. In addition to improving the timeliness, quality, and security of NJ's birth data, the adoption of a web-based EBRS would also facilitate real-time linkages to other data sets, thus laying the groundwork for the development of an electronic child health registry.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Annual Objective and Performance Data	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0
Numerator	6061	5825	5655	5421
Denominator	6061	5825	5655	5421
Is the Data Provisional or Final?	Final	Final	Final	Final

Source: NJ DHSS Newborn Screening Program

This data shows the number of unique infants identified as having an out-of-range newborn screening result for each year. All newborns with confirmed biochemical disorders received appropriate follow-up - see attached chart.

National Performance Measure Section

This Table represents the outcome of Newborn Screening test results for the 101,692 initial screens performed during Calendar Year 2011

Calendar Year 2011. Data prepared on 2/28/2012 [DOB 1/1/11 to 12/31/11; 101,692 initial samples; 152 still pending] **Newborn Screening Disorders**		# Babies with Confirmed Classic Disease	# Babies with Variant Disease or Carrier Status	# Babies with cleared results
Biotinidase Deficiency	BIOT	2	12	156
Congenital Adrenal Hyperplasia	CAH	6	3	528
Congenital Hypothyroidism	CH	80	12	1441
Cystic Fibrosis	CF	12	12	92
Galactosemia	GALT	1	24	47
Maple Syrup Urine Disease	MSUD	0	0	0
Phenylketonuria	PKU	1	5	4
Sickle Cell Anemia and Other Hemoglobinopathies Hemoglobin Traits	S/S, S/C, Var Hb 2888	33	38	1
Amino Acid Disorders				148
Homocystinuria	HCY	0	0	
Hypermethioninemia	MET	0	0	
Tyrosinemia	TYR	0	8	
Fatty Acid Disorders				65
Carnitine Uptake Defect	CUD	2	0	
Short Chain Acyl-CoA Dehydrogenase Deficiency	SCAD	0	1	
Glutaric Aciduria, Type II	GA-II	0	0	
Medium Chain Acyl-CoA Dehydrogenase Deficiency	MCAD	4	0	
Long/Very Long Chain Acyl-CoA Dehydrogenase Deficiency	LCAD/ VLCAD	3	0	
Long Chain 3-Hydroxyacyl-CoA Dehydrogenase Deficiency	LCHAD	0	0	
Trifunctional Protein Deficiency	TFP	0	0	
Carnitine Palmitoyltransferase Deficiency, Type II	CPT-II	0	0	
Carnitine/Acylcarnitine Translocase Deficiency	CACT	0	0	
Carnitine Palmitoyltransferase Deficiency, Type IA	CPT-1A	0	0	
Medium/Short Chain 3-OH Acyl-CoA Dehydrogenase Deficiency	M/SCHAD	1	0	
Medium Chain Ketoacyl-CoA Thiolase Deficiency	MCKAT	0	0	
Dienoyl-CoA Reductase Deficiency	DERED	0	0	
Organic Acid Disorders				68
Propionyl-CoA Carboxylase Deficiency	PROP	0	0	
Methylmalonic Acidemia [Mutase or Cobalamin Defects]	MUT/CBL	0	0	
Isobutyryl-CoA Dehydrogenase Deficiency	IBD	0	0	
Isovaleryl-CoADehydrogenase Deficiency	IVA	1	0	
2-Methylbutyryl-CoA Dehydrogenase Deficiency	2MBG	0	0	
3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency	HMG	1	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	3MCC	2	1	
Multiple Carboxylase Deficiency	MCD	0	0	
3-Methylglutaconyl CoA Hydrastase Deficiency	3MGA	0	0	
Glutaric Aciduria, Type I	GA-1	0	0	
Mitochondiral Acetoacyl CoA Thiolase Deficiency	BKT	0	0	
2-Methyl-3-Hydroxybutyric Acidemia	2M3HBA	0	0	
Malonyl-CoA Decarboxylase Deficiency	MAL	0	0	
Urea Cycle Disorders				3
Citrullinemia I + II	CIT	0	0	
Argininosuccinate Lyase Deficiency	ASA	1	0	
Argininemia	ARG	0	0	
TOTALS		150	117	2553

a. Last Year's Accomplishments

Newborn Screening continues to be an essential, preventive public health program for early identification of disorders that can lead to catastrophic health problems. The Newborn Screening and Genetic Services Program, which houses the follow-up component of newborn biochemical screening, ensures that affected newborns and their families receive prompt intervention by contacting primary care providers, physician specialists and parents to ensure evaluation, confirmatory testing, and a final diagnosis. All newborns with confirmed disorders received appropriate follow-up services – see attached chart.

In 2011, New Jersey's Newborn Screening Program continued to meet with the Newborn Screening Advisory Review Committee (NSARC) to develop recommendations concerning the management of residual dried blood spots. Recommendations are currently pending Commissioner Review. The Program continues to be in the forefront nationally in terms of the number of disorders for which screening is provided to newborns. Babies receive blood spot screening for 54 disorders in New Jersey. In 2010, Kathleen Sebelius, Secretary of Health and Human Services, endorsed the recommendation by the Advisory Committee for Heritable Disorders in Newborns and Children, to add newborn screening for severe combined immunodeficiency (SCID) to the Recommended uniform Screening Panel. In April, 2011, NSARC also voted to recommend adding SCID to New Jersey's newborn screening panel. This recommendation is currently under review by the Commissioner of Health. In 2012, legislation was passed mandating screening for 5 lysosomal storage disorders. This legislation does not go into effect until certain conditions, such as the existence of FDA approved reagents, are met. In the meantime, NSARC is continuing its review of lysosomal storage disorders.

Newborn screening was instituted in New Jersey in 1964 with the implementation of statewide screening for phenylketonuria (PKU). Screening expanded to include congenital hypothyroidism in 1978, galactosemia in 1982, and the hemoglobinopathies, including sickle cell disease in 1990. With advances in screening technologies and public advocacy for expanded newborn screening, in 2000, the New Jersey Department of Health and Senior Services (DHSS) convened an advisory panel of metabolic and genetic experts, parents, nurses, pediatricians and other health care professionals to closely examine New Jersey's program. Statewide public hearings were also held to enable interested parents, advocates and other concerned individuals the chance to voice their experience and concerns with newborn screening. In 2001, a significant expansion of the program was implemented with the addition of 4 more disorders: Maple Syrup Urine Disease, Cystic Fibrosis, Congenital Adrenal Hyperplasia and Biotinidase Deficiency. In 2002, screening continued to expand in New Jersey with the acquiring of tandem mass spectrometry technology. By the end of 2003, 12 more metabolic disorders were added to the panel. The last major expansion was completed in 2009 with the additional screening for 34 disorders.

Appropriate educational materials are also provided to hospitals, parents, physicians, and specialists. Educational materials have been prepared for parents and health care professionals. Pediatric specialty consultant groups agreed on using HRSA ACT sheets as a resource for physician information to replace the current physician information sheets at the time of expansion. In order to improve parent informational material, the program adopted new brochures, developed as a result of extensive HRSA and AAP funded studies. The brochures, entitled "These Tests Could Save Your Baby's Life," are available in English and Spanish and have been distributed to all New Jersey birthing facilities.

The DHSS recognizes that screening is only the first step in a state-mandated newborn screening program: successful programs require additional resources and funding to ensure immediate access to confirmatory testing, appropriate treatment and follow-up of each affected infant and family. Due to the nature of some of these disorders, a delay in confirmatory testing and/or treatment can be life threatening. Sub-specialists who can provide these essential services have been identified for the various disorders and funding has been committed to provide a statewide safety net of specialized diagnostic and treatment services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded screenings to include 54 newborn biochemical disorders.			X	
2. Tandem mass spectrometry technology has been implemented in the Newborn Screening Laboratory.			X	
3. Regional specialty care centers have been established and supported for affected newborns and their families.	X			X
4. Ongoing collaboration with specialists and pediatric primary care providers.				X
5. FHS and The Newborn Screening Laboratory, Division of Public Health Infrastructure Laboratories and Emergency Preparedness staff regularly meet with established specialty consultants.			X	X
6. Newborn Screening Annual Review Committee (NSARC) reconvened to advise Newborn Biochemical Screening Program.				X
8. Improvements in generic NBS parent pamphlets		X		
9. Follow-up protocols, new parent and physician fact sheets for expanded NBS.		X		

b. Current Activities

The Newborn Screening and Genetic Services Program currently collaborates with the Newborn Screening Laboratory, several specialty consultant groups, and the Newborn Screening Advisory Review Committee (NSARC) to continue to refine a best practice model for newborn screening services and follow-up. NSARC has recommended the addition of severe combined immunodeficiency (SCID) to the newborn screening panel and continues to discuss whether or not to recommend the addition of lysosomal storage disorders, ahead of the effective date of the recent legislation, to the screening panel. To address technological changes that have the potential for improving sensitivity, specificity and the scope of newborn screening services, the NSARC will continue to assess, evaluate, and make recommendations.

SCHEIS continues to provide partial support for the provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, hemoglobinopathies, and specialty laboratory services.

For each of the newborn biochemical disorders, semi-annual meetings continue to be held with the respective consultant groups to ensure that testing and follow-up procedures used by the State are reflective of best medical and laboratory practices. Additionally, the medical consultants represent the concerns of families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate medical care and treatment and identification of other unmet needs.

In 2011, Governor Christie signed legislation making NJ the first state in the nation to mandate pulse oximetry screening of newborns. NJDHSS worked with an expert consultant group to develop a recommended screening protocol for the hospitals. NJDHSS has developed a mechanism for collecting statewide surveillance data and is also working to develop educational activities and a Best Practice Guidelines document.

c. Plan for the Coming Year

The Newborn Screening and Genetic Services Program will continue to work with its many partners and consultants including the NSARC in 2012.

The Program will continue to meet regularly with specialty consultant groups in hematology, endocrinology, pulmonology, and genetic and metabolic medicine to determine appropriate cut-offs for screening tests, as well as follow-up procedures and general program operations.

The Program will continue to be represented and participate in local and national association meetings and activities which are designed to advance newborn screening practice. These include working with the New Jersey Human Genetics Association, the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services, and the American Association for Public Health Laboratories. The Program will also continue to provide data and respond to surveys as requested by the National Newborn Screening Information System, which is housed in The National Newborn Screening and Genetics Resource Center (NNSGRC). The NNSGRC is a cooperative agreement between the Maternal and Child Health Bureau (MCHB), Genetic Services Branch and the University of Texas Health Science Center at San Antonio (UTHSCSA), Department of Pediatrics.

In 2012, the Program will continue to work on having a module for newborn biochemical screening in the new electronic birth certificate. This module would help ensure that all newborns born in New Jersey receive newborn screening and enable easier tracking of affected newborns for follow-up. Web-based updates regarding newborn screening activities, policies and services will be made in accordance with any changes.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CYSHCN survey)*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective	59	60	61	62	56			
Annual Indicator	57.7	57.7	57.7	55.4	55.4			
Numerator								
Denominator								
Is the Data Provisional or Final?		Final	Final	Final	Final			

Notes – Indicator data comes from the National Survey of CYSHCN, a numerator and denominator are not available.

a. Last Year's Accomplishments

Annual audits of each of the 50 health service grantees was conducted by State staffs using standardized monitoring tools which included report of family involvement in program evaluation; i.e., family satisfaction surveys, focus groups patient interview and parent forums using standardized tools with open ended questions. State audit of clinical grantees included observation of parent-provider interaction during clinics, client chart review, and review and discussion of individualized service plan development with providers. Site visits afforded some observation of grantees' in-service training and team meetings. Examples of efforts by grantees' to ensure parent input included anonymous patient satisfaction and Press Ganey surveys, parent attendance and participation at team meetings, and family satisfaction surveys that had been completed anonymously by parents. Parent responses were reviewed by the local project Coordinator and shared with staffs to revised practice and incorporate family input into the delivery of services; i.e., revisited scheduling and office practices, language translation supports. Title V consultation and technical assistance was provided on an as needed basis.

Through a collaborative effort with the State Early Hearing Detection and Intervention (EHDI) program and using one time funding, 5 focus groups were conducted by the FCCS family support grantee, SPAN's Project Family WRAP, to gather family input on satisfaction with hearing screening, diagnostic and

educational and family supports. Twenty-eight parents participated and represented English speaking, non-English speaking, bilingual and hearing impaired parents of biological and adopted children with hearing loss. Parent responses demonstrated that most of the families were linked to care and resources and were satisfied with those services. However, they remarked about feeling isolated, wanting to meet other parents of children with hearing impairment and needing more support at points of transition.

Progress was made by the State SCHS CM, State BDARS, Rutgers University and the county SCHS CMUs in implementing the CDC Surveillance project. Both the electronic transmission of Registration data, and the Case Management Reporting System (CMRS) module went live in 2011, and 100% of the CMUs are now online. Historically, State SCHS CM staffs needed to view hard copy records of a child's BDR and individualized service plan (ISP) to conduct audits. The electronic record is anticipated to allow State staffs more access to client's records and consequently more opportunity to validate family partnering in ISP development and satisfaction with services.

To ensure family partnership and satisfaction, the SCHEIS ensures access to SCHS case management family support and specialized pediatric services for CYSHCN and their families. This is being conducted formally through annual State SCHEIS monitoring and technical assistance of the 50 health services grants, as well as through discussion of those agency's findings gathered from family satisfaction surveys, focus groups and quality assurance initiatives. Consultation and collaboration is provided by State staffs to ensure that findings noted on individualized service plans and progress notes incorporate family driven needs identified by CYSHCN and their families. Likewise, consultation and technical assistance is provided on an as needed basis in developing resources in response to family satisfaction surveys, focus groups and quality assurance initiatives. In addition, SCHEIS collaborates with community- based partners including SPAN, other Consortium Care members and families to assess family satisfaction and engage parents and CYSHCN in decision making.

On the programmatic level, annual audits of each of the 50 health service grantees are conducted by State staff using standardized monitoring tools which include report of family involvement in program evaluation: i.e., family satisfaction surveys, focus groups, patient interviews, and parent forums using standardized tools with open ended questions.

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SPAN		X		X
2. Parent-to-Parent Network		X		X
3. Statewide Family Voices chapter		X		X
4. Family satisfaction surveys, focus groups and/or additional methods of evaluation to be conducted periodically by SCHS CM, Specialized Pediatric Services, Family WRAP providers to measure family satisfaction.		X		X
5. SCHS CMU CDC Surveillance Project		X		
6. Statewide Integrated Systems grant in collaboration with SPAN and Consortium of Care partners		X		
7. NJ Council on Developmental Disabilities		X		X
8. Quality assurance project on access to hearing aids through Fee-for-Service program		X		X

b. Current Activities

Fifty health service grants partially support Title V services through the FCCS programs. To ensure family partnership and satisfaction, the SCHEIS ensures access to SCHS case management, family support and specialized pediatric services for CYSHCN and their families. This is being conducted formally through annual State SCHEIS monitoring and technical assistance of the 50 health services grants, as well as through discussion of those agency's findings gathered from family satisfaction surveys, focus groups and quality assurance initiatives. Consultation and collaboration is provided by State staffs to

ensure that findings noted on individualized service plans and progress notes incorporate family driven needs identified by CYSHCN and their families. Likewise, consultation and technical assistance is provided on an as needed basis in developing resources in response to family satisfaction surveys, focus groups and quality assurance initiatives. In addition, SCHEIS collaborates with community-based partners including SPAN, other Consortium of Care members and families to assess family satisfaction and engage parents and CYSHCN in decision making.

On the programmatic level, annual audits of each of the 50 health service grantees are conducted by State staff using standardized monitoring tools which include report of family involvement in program evaluation; i.e., family satisfaction surveys, focus groups, patient interviews, and parent forums using standardized tools with open ended questions. Family feedback is reviewed by State and local staffs and considered in program planning.

State staffs are continuing with training and technical assistance of SCHS CMUs, and technical assistance with BDARS and Rutgers staffs to implement electronic records through CMRS. This system will facilitate access to SCHS CMU client records, and allow for more flexibility in monitoring of individual service plans for parent involvement in decision making and satisfaction with services.

c. Plan for the Coming Year

SCHEIS will maintain its network of providers to ensure access to culturally competent community-based care for CYSHCN, and its partnership with SPAN and PCORE in the ISG Consortium of Care. Contractual language will remain to encourage grantees to collect family input data through surveys, interviews and focus groups, and to integrate that feedback to improve service delivery in a culturally competent manner. Continued CMRS training and technical assistance for State and county based SCHS CMU is ongoing. State staffs will revise training documents as revisions of the system are released. State staffs plan to pilot an online chart review and assess ISPs for parent input.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CYSHCN Survey)*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective	55	56					
Annual Indicator	52	52	40.8	40.8	40.8		
Numerator							
Denominator							
Is the Data Provisional or Final?	Final	Final	Final				

Notes - Indicator data comes from the National Survey of CYSHCN, a numerator and denominator are not available.

a. Last Year's Accomplishments

Monthly Core Team ISG meetings with SPAN, PCORE, Title V and the Department of Children and Families (DCF) were conducted to discuss strategies and progress in addressing CYSHCN's access to medical home. The Team continued to collaborate on and implement the ISG 1 statewide plan including integration of ISG 2 autism content, to meet with pediatricians, family practitioners and federally qualified health centers and promote access to a medical home for CYSHCN. Lessons learned from the Monmouth county pilot project; i.e., practices to self-identify needs to develop their AIM/PDSA statements; support practices to define and identify CYSHCN in their individual practices; engage parent partners as members of the Medical Home QI team, etc., were applied. State Title V and county based SCHS CMUs contributed consultation and lists of primary care providers to initiate the ISG expansion into the southern (Camden, Gloucester and Salem counties), central (Middlesex county) and northern (Essex county) areas of NJ.

Regional medical home kick-off events and learning sessions were replicated in each region. Title V provided overviews of the role of Title V in ensuring access to care for CYSCHN, and linkage with primary and specialty pediatric services. Conference calls and webinars provided additional technical assistance to practices, including a co-teleconference by State SCHS CM and State Autism program; Title V and You, Access to Care for CYSCHN.

Preliminary results for the southern medical home initiative (10 practices) indicated improvement in practice familiarity with Medical Home and Family-Centered Care concepts. Family Feedback Surveys (200) regarding their practice suggested confidence that they could get the health care that their child needs (78.4%), their healthcare provider listened to their concerns and questions (82.6%). Interestingly, parents also reported their top 3 out-of-pocket expenses; payment co-pays, out of network care, and treatment/therapies not covered by their insurance.

	Pyramid Level of Service			
Activities	**DHC**	**ES**	**PBS**	**IB**
1. Case Management Services		X		
2. NJ AAP/PCORE Medical Home Projects		X		
3. Medicaid Managed Care Alliances				X
4. Subsidized Direct Specialty and Subspecialty Services	X	X		
5. Participation in Medical Assistance Advisory Council		x		

b. Current Activities

Title V programs and services continue to ensure statewide access for NJ's CYSCHN to primary care and SCHEIS subsidized direct specialty and subspecialty care. Eleven comprehensive Child Evaluation Centers (CECs), 5 Cleft Lip/Palate Centers, and 3 Tertiary Care Centers continue to provide access to comprehensive multidisciplinary team based-evaluation and/or treatment, regardless of the client's ability to pay. The provision of coordinated, ongoing, comprehensive care, including assistance with care coordination and linkage with a primary care provider/pediatrician supports appropriate care in the child's medical home. Although, the medical fragility/rare conditions of some CYSCHN presents challenges in accessing primary care through a community-based provider and the pediatric specialist serves dual roles; specialist and primary.

The Centers are recognized by NJ DHS's Medicaid managed care system as Centers of Excellence, are commonly referred clients by community-based providers including pediatricians, child study teams, DCF Child Behavioral Health and other community-based providers. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs.

Referral to and coordination with in-State specialty care providers was a component of technical assistance provided through the ISG medical home project. To that end, in collaboration with the Arc of NJ's Mainstreaming Medical Care initiative, Title V State staffs in collaboration with two regionalized comprehensive CECs experts authored and published an article in Arc's fall 2011 Healthy Times Newsletter. Broadly distributed to families and providers, and available on the Arc's website, the article describes services, eligibility, and cost for an evaluation at the CEC's and the CEC Fetal Alcohol Syndrome Disorder programs.

c. Plan for the Coming Year

The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSCHN throughout 2013. State programmatic monitoring to ensure that clients have and/or are referred to community-based providers will remain ongoing; audit visits to assess clinic days and provide consultation as well as follow-up telephone support will continue. Continued collaboration with the DHS Office of Medicaid Managed Care and the ISG medical home initiative are anticipated. The ISG initiative will expand into northwest (Sussex, Warren and Morris counties), winter 2012. Title V will continue to

collaborate, link providers and families of CYSCHN to care coordination and pediatric specialty care services in that region of NJ.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CYSHCN Survey)*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective	63	63	64	64	64			
Annual Indicator	62.1	62.1	62.1	62.1	62.1			
Numerator								
Denominator								
Is the Data Provisional or Final?		Final	Final	Prov				

Notes - Indicator data comes from the National Survey of CYSHCN, a numerator and denominator are not available.

a. Last Year's Accomplishments

Understanding, integrating and supporting families through major health insurance and health services systems shifts was a big focus in 2011, and it is anticipated to continue into 2012. The Medicaid Comprehensive Waiver, mandatory Medicaid Managed Care (MMC), federal healthcare reform, coordination of care integrating third party liability, as well as the challenges of being underinsured and uninsured presented a dynamic environment of change for Title V programs/service providers, CYSHCN and their families. Likewise, the reorganization of some State agencies contributed to relearning about services and systems by State and local agencies and families of CYSHCN. In spring 2011, NJ released a Medicaid concept paper outlining significant changes to its Medicaid system, followed by public input and submission of a formal Comprehensive Waiver application that remains pending at this time. Mandatory enrollment of all Medicaid clients into MMC including SSI and waiver clients was implemented in fall 2011. Title V SCHS CM State, SCHS CMUs and Specialized Pediatric Services (SPS) providers worked quickly to identify CYSHCN in their caseloads potentially affected by these changes, facilitated HMO enrollment, advocated with State and MMC HMOs and supported families through their transition. The DHS' Office of Home and Community Services collaborates regularly with the MMC HMOs, Title V and the SCHS CMUs on ensuring access to waivered services. State Title V staffs met quarterly with the Office of MMC, DHSS Senior Services, DHS Office of Home Care and the MMC HMOs to facilitate dialogue about systems issues.

At point of referral and periodic monitoring, families of CYSCHN were screened for the following: health insurance status; comprehensiveness of their plans to meet their special needs; NJ FamilyCare; NJ Advantage; private insurance; Charity Care/sliding fee scale; charitable foundations; and the need for assistance with outstanding medical debt through the Catastrophic Illness in Children Relief Fund (CICRF). No one is turned away from Title V services due to the inability to pay. 100% of applicants to the CICRF were referred to the SCHS CMU in their county of residence for assistance with care coordination and screening for additional socioeconomic supports as well as health and related services. The SCHS CMUs and the SPS providers demonstrated that they remain knowledgeable about Charity Care, community-based charities and/or foundations in their regions that may assist to defray medical and related expenses and keep a family home. For example, a 16 year old CYSCHN diagnosed with cerebral palsy and quadriplegia was referred to an SCHS CMU by the SSA referral system. Upon outreach it was determined that although the child had a motorized wheelchair, there was no access to the home or van. The family could not afford to move or to build a handicapped ramp. The SCHS CM collaborated with multiple public and private agencies to mobilize support for the family to build a ramp; i.e., County Office of Disability, Healing the Children, Habitat for Humanity, a local real estate and construction company, local high school students and a men's church group. The ramp is anticipated to be built in spring 2012.

Participation in ISG activities provided opportunities to educate participating providers about Title V services and linkages with DHS Medicaid, presumptive eligibility, waivers, NJ FamilyCare, CICRF, SPS providers and other agencies and supports for CYSHCN that remain uninsured or underinsured. Preliminary ISG family survey data from the south Jersey medical home initiative suggested that of 200 baseline Family Feedback Survey's returned from participating practices, parents of CYSHCN identified 3 top out-of-pocket expenses; payment of co-pays, out of network care, and treatment/therapies not covered by their insurance. Title V shared with ISG participating agencies that strengths in referring clients to the SCHS CMU in their county of residence include potential assistance in developing a CICRF application, referral to charitable assistance and/or financial counseling if out-of-pocket expenses for care and treatment were more than they could afford.

Adequate authorization and payment for specialized infant and pediatric formula for CYSCHN with metabolic disorders was addressed with the DHS, Office of MMC. The DHS hosted a meeting with Title V and the DHS MMC HMO providers to explore challenges in access. Policy and procedure and WIC services were revisited and clarified.

State staffs collaborated with the DHSS and community-based agencies to develop public information messages to promote awareness about the needs of CYSCHN and disabilities; i.e., National Organ Donation Month, Governor's proclamation for Autism Awareness Month.

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. County Case Management		X		
2. Subsidized Direct Specialty and Subspecialty Services	X	X		
3. Collaborate with the Catastrophic Illness in Children Relief Fund			X	
4. Collaborate with NJ Department of Banking and Insurance		X		
5. Medical Assistance Advisory Council		X		
6. NJ Hospital Association Health Research & Educational Trust CHIPRA Coalition		X		
7. ARC of NJ		X		
8. SPAN ISG 1 and ISG 2		X		
9. Collaborate with NJ DCF			X	
10. Collaborate with NJ DHS, Medicaid			X	

b. Current Activities

The Title V State office and programs collaborate with SPAN, PCORE and other Community of Care Consortium (COC) members to promote access to adequate and comprehensive insurance coverage for CYSCHN including underserved minority and/or limited English proficiency through the Adequate Insurance Workgroup.

State staffs collaborated with the BDARS, Rutgers University and the SCHS CMUs on implementation of the Centers for Disease Control (CDC), Case Management and Reporting System (CMRS). State staffs conducted statewide training of the SCHS CMUs to facilitate implementation of electronic reporting and receipt of BDRs. 100% of the SCHS CMUs are live. This exciting innovation is anticipated to provide electronic access to BDARS data as well as information included on the CYSCHN's individualized service plan, including insurance status and other health and social service needs. Technical assistance is ongoing to facilitate policy development, problem solve and plan for system modifications.

State staffs collaborated with Medicaid and the SCHS CMUs to facilitate mandatory MMC enrollment for all current Medicaid clients. In addition they provide technical assistance and guidance to grantees and families, as well as, participate at Medical Assistance Advisory Council (MAAC) meetings. Waiver trainings and revision of the consumer tool, "Finding Your Way through Medicaid Managed Care." State staffs also provide technical assistance to consumers via telephone, examples of requests for assistance

include; i.e., clarification and assistance with problem resolution regarding enrollment, how to select an HMO for clients seeing multiple specialists, access to local in-State and/or out of State specialty care, clarification of access to services such as pediatric medical day.

c. Plan for the Coming Year

State staffs will continue to collaborate with the BDARS, Rutgers University and the SCHS CMUs on implementing and refining the Centers for Disease Control (CDC), Case Management Reporting System (CMRS).

It is anticipated that there will be additional reorganization of DHS services as proposed in the Medicaid Comprehensive Waiver. Components of the DHS' Division of Disability Services addressing children and youth is expected to be reorganized into the DCF. Likewise, some programmatic reorganization within both the DHS and the DCF are anticipated. As a follow-up to previous meetings, Title V will revisit the proposed reorganization of those Departments services to dialogue about access to services and supports for CYSHCN warranting medical, developmental and behavioral services; access to care and adequate payment.

Title V will continue to collaborate with intergovernmental and community-based partners described above to promote awareness about changes in NJ's public and private health insurance landscape through trainings and participation on the ISG 1 and ISG 2 projects.

SCHS CMU and SPSP providers will continue to screen CYSHCN for insurance status, refer clients to the Department of Banking and Insurance, Boards of Social Services, and NJ FamilyCare Outreach programs, as needed to facilitate access to comprehensive coverage. Likewise, they will continue to document and track CYSHCN's insurance status. State staffs will continue to monitor grantees' insurance status data and provide technical assistance and guidance to providers and consumers in their efforts to assist families to navigate access to care.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CYSHCN Survey)*

[**Annual Objective and Performance Data**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	77	78	79					
Annual Indicator	75.9	75.9	75.9	88	88			
Numerator								
Denominator								
Is the Data Provisional or Final?		Final	Final					

Notes - Indicator data comes from the National Survey of CYSHCN, a numerator and denominator are not available.

a. Last Year's Accomplishments

Title V maintained an organized system of Special Child Health and Early Intervention Services (SCHEIS) to ensure the early identification and reporting to BDARS of CYSHCN, follow-up, linkage to care and family support. The system of early identification through newborn screening, reporting to the BDARS, follow up by the SCHS CMU's, support from Family Resource Specialists and referral to the Specialized Pediatric Services providers, other community-based programs and services enabled a structure to identify CYSHCN and link them with care. SCHEIS collaborated with the County Boards of Chosen Freeholders to maintain the network of 21 county-based SCHS CMU's and linked over 12,000 CYSHCN with community-based services. In collaboration with SPAN, 20 SRS were housed in and/or linked with SCHS CMU's to enable SRS to reach out to families to provide family support.

Likewise, SCHEIS partnered with community-based hospitals to maintain regionalized Specialized Pediatric Services including Child Evaluation Centers, Cleft Lip/Palate Centers (CEC), Tertiary Care Centers and the Ryan White Family Centered HIV Care Network to ensure access to care, afford collaboration on developing support systems with families and linkage to community-based resources. These systems of care are deliberately organized to provide opportunities for consultation with and cross referral on needs for CYSHCN's and their families and specialty providers. Co-locating some of the SCHS CMUs with specialty providers continued to facilitate access. In addition, the State funded 6 autism clinical enhancement centered regionally located throughout NJ to afford families access to care, 3 of which are co-housed with Child Evaluation Centers and 2 are co-housed with SCHS CMU's. Some agencies also reported hosting a NJ FamilyCare outreach worker on site to enable families to complete and/or follow-up on their applications.

A letter of agreement with the Catastrophic Illness in Children Relief Fund enabled cross referral between our systems to screen families with CYSHCN experiencing medical debt related to their child's care and linkage with SCHS CMU's and family support. Collaboration with State, federal and local partners enabled coordination across systems and access to related medical, developmental, educational, rehabilitative and social, emotional and economic supports. Examples of collaborative partners includes the DHS Medicaid, waiver and NJ FamilyCare and Division of Developmental Disabilities programs (DDD); Department of Education Office of Special Education; DCF's Children's Behavioral Health Services and Family Support; Department of Labor's Disability Determinations and Vocational Rehabilitation; SPAN's ISG Consortium of Care (COC) and Family WRAP; Arc of NJ and other disability specific organizations; and charities. Organizing systems of care to enable families to be linked with pediatric specialized services and/or enhanced capacity without duplication of services was accomplished by formal and informal partnering with State and community-based agencies.

The SCHEIS State office and community-based providers, SPAN's ISG 1 and 2 and Family WRAP activities, NJ PCORE's medical home initiatives and families provided input on the accessibility of community-based services for CYSHCN and their families. The NJ PCORE Monmouth county medical home project initiated two years ago with one-time Title V support was partially supported by ISG funding. This financial support extended medical home projects into southern, central and northern NJ. A key construct of the project has been the participation of practice based Parent Partners as a mechanism to support parents of CYSHCN, measure and incorporate their input into the practice model, thereby enriching the "medical homeness" of service delivery. The ISG partners in each region including SCHS CMUs, specialty providers and disability specific organizations contributed to community mapping of county, regional, State and national healthcare resources. These resources were provided to practice-based care coordinators, Parent Partners and providers to more readily identify service systems to support CYSHCN in their communities. In addition, each of the ISG participating practices recruited Parent Partners and SPAN provided telephonic support and face to face trainings for those families. Topics such as care plans for a CYSCHN, community road maps and individual health plans were discussed at a one day Parent Partner training, followed by an onsite orientation visit. Resources provided by ISG Core Team members were also supplied to the practice and Parent Partners.

Enhanced capacity through SPAN's ISG 1 and 2, and Parent Training Institute grants partially supported the SPAN Family WRAP initiative. Five additional SPAN Resource Specialists had been trained and are being housed at SCHS CMUs; Cape May, Cumberland, Burlington, Salem and Gloucester. This collaborative initiative between SPAN, Title V and the SHCS CMU grantees brings the total number of SCHS CMUs with either onsite part-time family support or SPAN designated parent support to 17 counties. These family support specialists are parents of CYSHCN and collaborate with the SCHS CMUs to ensure statewide access to family support, referral to SCHS CMUs and Early Intervention Services, specialty providers and other community-based resources.

Mini grants made available through ISG facilitated access to services. An example includes the Burlington County SCHS CMU had self identified a need to enhance cultural competence among the Hispanic community, particularly those families with limited English proficiency. The Burlington County Department of Health, host agency of the Burlington County SCHS CMU, applied to and received one

time funding to support outreach to Hispanic families and community based organizations. This collaboration led to dialogue with families to better serve their needs and a revised bilingual brochure for the Burlington County SCHS CM to use in future outreach.

The Mercer county SCHS CMU conducted follow-up on failed newborn hearing screening that were lost to follow-up by their birthing facility. Outreach efforts have included multiple telephone calls to the family, use of language line translation services, contacts to providers to encourage call-back and to the SCHS CMU in the child's county of residence have produced results. Families were linked with resources in their communities including referred to their county based SCHS CMU, Board of Social Services, CICRF, audiologists, primary care providers and others as needed.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide Parents Advocacy Network			X	
2. Parent-to-Parent Network			X	
3. Family Voices parent group			X	
4. PCORE			X	
5. SCHS CMUs			X	
6. Child Evaluation Centers				X
7. Autism Clinical Enhancement Centers				X
8. SPAN ISG 1 and ISG 2			X	
9. CDC Surveillance project			X	

b. Current Activities

Subsequent to NJ's Comprehensive Waiver application, Title V has engaged in enhanced collaboration with the DHS Office of Medicaid Managed Care, Office of Home and Community Based Services, Medicaid managed care organizations, DHSS' Global Options staff, NJ's MAAC and other State, local and advocacy organizations and providers. This collaboration has presented opportunities to train and/or retrain those entities on the role of Title V and facilitate case finding. For example, Title V was recently invited to present an overview of its role in serving CYSHCN by the NJ AAP's CSHCN committee, and States staffs conducted an evening teleconference to promote linkage to Title V services for their populations with special needs.

The State SCHEIS program networks with partners in the disability community such as the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Center for Excellence in Developmental Disabilities Education, Research and Service to outreach to underserved populations. Title V State staff presented an overview of SCHEIS services at the Bogg's Centers program; Arab American Communities and Disabilities Conference: Getting to Know You, Getting to Know Us. The conference provided a full day of multi-cultural outreach and promotion of Title V services, and a better understanding of Middle Eastern cultural beliefs and practices in raising CYSHCN.

Continued participation in ISG 1 & ISG 2 medical home initiatives affords opportunities for parent champions at participating medical practices to outreach to parents whose children are receiving medical care through a pediatric/family practice and link them with additional family support and/or education services. Traveling throughout NJ to participate in medical home events, presenting about access to Title V services, and introducing local providers, advocates and family support agencies to county based SCHS CMUs and/or regionalized SPS providers promotes linkages and cross referral.

The State SCHEIS staffs and SCHS CMU's, SPAN Resource Specialists and SPS providers conduct outreach efforts to assist families of CYSHCN to identify community-based services and supports by partnering with State and community-based agencies. Examples of community-based outreach include collaboration between SCHS CMUs and SPAN Resource Specialists to conduct family support/awareness meetings, medical grand rounds, medical home events, disease specific family support programs and cleft palate youth support groups.

The Mercer county SCHS CMU conducts follow-up on failed newborn hearing screening that are lost to follow-up to their birthing facility. Upon following up and contacting families of CYSHCN, intake is conducted and needs are identified. Families are linked with resources in their communities including their county based SCHS CMU, Early Intervention Services, Board of Social Services, CICRF, audiologists, primary care providers, and others as needed.

Collaboration with the DHSS' Office of Public Information provides opportunities to promote awareness about pediatric disorders or special needs and encourage families with CYSHCN to link to services; i.e., National Organ Donor Day and Autism Awareness Month.

c. Plan for the Coming Year

State SCHEIS staffs and SCHS CMUs and SPS agencies will continue to engage in the ISG initiative with SPAN and PCORE. This collaboration will maintain the availability of SPAN Resource Specialists in each county, serving as a cross referral and family support. Likewise, the ISG affords opportunities for providers and Parent Partners to link families of CYSCHN with county and State Title V supports. The northwest region of NJ is targeted for the next ISG medical home intervention.

Continued collaboration between SPAN, SCHEIS and other community-based partners will continue to enhance the provision of accessible family-centered care. SPAN Resource Parents will provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. SCHEIS will continue to collaborate and partially support a Family Voices chapter. Likewise, SCHEIS will continue to provide intra/intergovernmental and community-based technical assistance to facilitate access to care for CYSHCN.

Following the Beta testing of the BDARS CDC Surveillance project implementing electronic referral of registrations to the SCHS CMUs in July 2011, all 21 county based SCHS CMUs are now receiving and submitting BDARS with the State office Training on the BDARS and the CMRS system was provided by State staffs in multiple formats; live on-site, off-site and remotely. State SCHS and SCHS CMU staffs are collaborating on implementation of the system; debugging, policy and procedure development, technical assistance. Lessons learned from the SCHS CMUs and State staffs are shared among the CMUs by the State office regularly through a Helpful Tips worksheet. As records become populated within the system, State and CMU coordinators will become more proficient in using the system and the database is anticipated to provide information such as trends in community access to care and supports.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective	7	8						
Annual Indicator	5.8	5.8	37.9	37.9	37.9			
Numerator								
Denominator								
Is the Data Provisional or Final?	Final	Final	Final					

Notes - Indicator data comes from the National Survey of CYSHCN, a numerator and denominator are not available.

a. Last Year's Accomplishments

Although the majority of CYSNCN served across the FCCS provider agencies were under aged 14, youth (14-21 years of age) comprised 10-14% of the population services. The coordination of access to transition supports and planning for those clients was initiated on or about age 14. In collaboration with SPAN, SCHS CMUs, parents of CYSHCN and other community-based partners, transition to adulthood packets provided by SCHS CMUs to transitioning youth and their families were updated. The packets included current resources such as local vocational rehabilitation and DHS Division of Developmental Disabilities contacts, guardianship, individual health plan development, Section 504 planning and Americans with Disabilities Act, Social Security and basic rights in transition. As the SCHS CMUs contact active clients approximately 14 years of age for monitoring and/or individualized service plan updates, families are encouraged to develop a goal for their CYSHCN to work toward transition to adulthood. Community-based resources are provided, including information on available transition to adulthood workshops through SPAN, local school districts, Department of Labor Division of Vocational Rehabilitation, as well as the transition to adulthood resource packet. These resources are revisited at subsequent monitoring.

Through the ISG activities, over 20 youth with a diverse range of SHCN from 11 counties have been recruited to serve on a Statewide Youth Advisory Council (SYAC). The SYAC is working to develop strategies to (a) provide YSHCN with the skills and opportunity to participate in decisions affecting their own transition to adulthood, (b) strengthen the voice of YSHCN in planning, implementation, and evaluation of integrated, community-based systems of care, and (c) build capacity of parent and professionals to work with YSHCN to facilitate effective transitions. Examples of these two activities included participation in webinars, teleconferences and meetings to learn about transition resources and to share their experiences.

In addition, through Family WRAP with SPAN, numerous transition teleconferences were conducted and archived onto SPAN's website, accessible 7 days/week, 24 hours/day for youth, parents and providers as well as downloadable resources. Span Resource Specialists (parents of CYSHCN trained through Family WRAP to support other parents) in collaboration with the SCHS CMUs provided presentations at family support group meetings.

The Specialized Pediatric Services (SPS) providers conducted evaluations and developed service plans with adolescent CYSCHN and their families. In addition, SPS providers reported providing youth with transition to adulthood resources regarding genetics, family medicine and other medical related needs. In addition, a Cleft Center reported having several "graduates" that have offered on line support to their peers through FaceBook and a teen support group.

Transition to adulthood services and supports training was provided by the DHS, Division of Developmental Disabilities (DDD) staffs to the SCHS CMUs. Program updates were provided, resources were shared and questions were clarified. In addition, DDD staffs explained their role in transition planning for youth with DD and the DDD Priority Waiting List, eligibility for the Community Care Waiver, options for self-direction through the Real Life Choices program, and guardianship.

Collaboration with SPAN's ISG 1 and 2 continued with planning and implementation transition to adulthood activities with the Youth Advisory Council and with pediatric providers through medical home activities. Strategies were explored to support medical home Parent Partners in educating and supporting parents of CYSHCN and practice providers to facilitate transition to adulthood. Resources to support families and youth through the transition process were provided to the practices.

Unfortunately, due to a lack of funding, the SSI Alliance conference scheduled for fall 2010 has been postponed indefinitely. In the interim, State Title V staffs continue to collaborate with the SSA and NJ Department of Labor Disability Determinations Unit staffs to ensure communication to community-based providers and SCHS Case Management Units are informed of changes in SSA eligibility, services and supports. During the Fall, 2011, Title V State staffs and SCHS CM staffs participated in training conducted by the Bar Association on federal health care reform, and anticipated changes to Medicaid and Medicare for persons with disabilities. The spring quarterly SCHS CMU meeting will focus on the SSI

eligibility criteria, assisting a client with how to submit an application and follow-up. State DOL Disabilities Determinations and SSA colleagues will present at the statewide meeting.

Through ISG 1 & ISG 2 State staffs collaborated on program planning to enhance interagency collaboration on transition to adulthood supports for youth with SHCN and their families. They also explored resources and supports across governmental and community-based programs; i.e., Department of Labor Vocational Rehabilitation, Department of Education and DHS Division of Disability Services, and shared those resources with the SCHS CMUs for dissemination via their county specific transition packets.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition to adulthood needs assessment		X		
2. Transition planning for CYSHCN in SCHS Case Management		X		
3. SPAN/ISG 1		X		
4. ARC of NJ		X		

b. Current Activities

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above are shared with families and linkage with community-based supports is provided. State staffs monitor the SCHS CMU's efforts to inreach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

The ISG 1 and 2 transition to adulthood activities include dissemination of transition to adulthood materials to medical practices, youth and families of CYSCHN, including transition in archived teleconferences and engaging the Youth Advisory Council (YAC) in review and dissemination of materials. Community-based partners continue to identify a resources and linkages are being made through SPAN's transition to adulthood project and community-based organizations that support CYSHCN.

Collaboration with community partners remain an essential strategy in supporting CYSHCN to prepare and experience transition. Some examples of supports being provided to CYSHCN and their families include home visits to assist with applications to DDD services and SSI applications; one on one telephone family support to assist with linkage to guardianship; resources; and collaboration between the CYSHCN, parents, SCHS CM and SPAN Resource Specialist to problem solve family concerns prior to a high school EIP meeting to prioritize wants and needs for the youth's career planning.

c. Plan for the Coming Year

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above will continue to be shared with families and linkage with community-based supports is provided. State staffs will monitor the SCHS CMUs efforts to inreach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

The SCHS CMUs will continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the individual service plan. Likewise, exploring youth and their parents' needs to facilitate transition; insurance, education, employment, housing, and linking them to community-based partners.

SCHS CMUs and pediatric specialty providers will refer youth and/or their parents to NJ CDD for participation in Partners in Policymaking self advocacy training as well as continue to assist youth and their families to advocate for transitional supports through their individualized education plans and community-based supports.

The SPAN ISG 1 initiative is planning to move forward in development of a Youth Advisory Council (YAC). The YAC is intended to provide a forum for empowering approximately 15 youth to develop leadership and self/group advocacy skills. It is anticipated that the YAC will link with other YSHCN that are currently informally meeting and participating in self advocacy, to develop a statewide resource and a voice for YSHCN in access to health care, social supports, employment, housing and other needs to establish successful transition to adulthood.

Through ISG 1 & ISG 2, Consortium of Care partners look forward to continued participation of YAC members in conducting school and community based outreach and workshops to support other youth in developing transition to adulthood plans.

Under health care reform, Medicaid will expand in 2014 to cover additional beneficiaries. As this population is intended to include a significant percentage of childless adults with incomes below 133 percent of FPL it is anticipated that CYSHCN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31) and/or . In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange. Title V will continue to participate in the discussion of NJ Medicaid, Department of Banking and Insurance regarding insurance benefits to support CYSCHN's transition to adult health care and related services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective					70	70	70
Annual Indicator	78.2	78.8	82.3	72.8	70.2	67.0	
Numerator							
Denominator							
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	

Notes - Data is from the National Immunization Survey Q1/2010-Q4/2010 at the CDC, The data is reported as 67.0% ± 6.7% for 4:3:1 plus full series of Hib vaccine, 3 or more doses of HepB vaccine, and 1 or more doses of varicella vaccine. http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010.htm
No numerators or denominators are available.

a. Last Year's Accomplishments

Vaccines help prevent infectious diseases and save lives. Vaccines prevent disease in the children who receive them and protect those who come into contact with unvaccinated individuals. Vaccines are responsible for the control of many infectious diseases that were once common in this country, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenzae type b (Hib).

New Jersey had achieved an 82.3% age appropriate immunization rate in 2007, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Vaccine Preventable Disease Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers (FQHCs), and private provider offices and other pediatric clinics. The State's Vaccines For Children Program became available to private practitioners and public health facilities for the first time in 1999. The Division of Family Health Services (FHS) continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

The NJ Immunization Information System (NJIIS) is the statewide immunization information system serving as the official repository of immunizations administered to children in New Jersey. The NJIIS has been operating since 1997 and is in use at more than 600 sites throughout New Jersey, with more than 6,563 active users with more than 2,790,116 patient records currently in the system. Most children are enrolled in the system through the electronic birth certificate record process. Each year approximately 88,459 more newborns are enrolled into the system.

The New Jersey Department of Health and Senior Services began the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry on May 2, 2003, through a series of introductory efforts sponsored by the regional Maternal Child Health Consortia.

The NJIIS is a confidential, population-based, computerized information system that allows NJDHSS to collect and consolidate vaccination data about children within a geographic area and cumulatively statewide. Registries are an important tool to increase and sustain high vaccination coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices for each child, and providing vaccination history documents, and performing vaccination coverage assessments. Electronic interfaces with practice management and electronic health record systems have increased to over 600.

The NJIIS allows providers to obtain a complete and accurate immunization history for a new or continuing patient, produce immunization records, reduce paperwork, manage vaccine inventories, introduce new vaccines or changes in the vaccine schedule, interpret the complex immunization schedule, and provide immunization coverage data for physician offices, health plans, and other organizations.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Immunization Program in Communicable Disease				X
2. NJIIS web-based registry			X	
3. NJ Vaccines for Children Program			X	
4. Local health department child health conferences		X		
5. Universal Child Health Record for all children in child care			X	
6. Legislated immunization requirement for school attendance		X		

b. Current Activities

All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. In 2004, the Statewide Immunization Registry Act was signed into law requiring all providers who administer immunizations to children under 7 years of age to input the data into the NJIIS within 30 days of administration. The full implementation of the law and the corresponding rules become effective December 31, 2011. Interfaces with private insurance carriers, Medicaid HMO's, hospitals and public health clinics and physicians billing companies are populating the registry with vaccination data. Their input has assisted in increasing the number of administered shots in NJ to 28,484,866. Registry interfaces with the programmatic requirements of WIC, Medicaid, Surveillance and the Vaccine Preventable Disease Program continue to enhance the registry's effectiveness as a viable medical tool.

NJDHSS revised the administrative rules (N.J.A.C. 8:57-4) with substantive changes to include the requirement of four new vaccines (Diphtheria and tetanus toxoids and pertussis vaccine,

Pneumococcal conjugate vaccine, Influenza vaccine, and Meningococcal vaccine) for school, preschool and licensed child-care center attendance beginning in September 2008. A summary of the changes is available at http://www.state.nj.us/health/cd/documents/vaccine_qa.pdf.

c. Plan for the Coming Year

FHS continues to work collaboratively with the Vaccine Preventable Disease Program to promote age appropriate immunizations. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through compilation of all immunization data relevant to the specific patient. Over 600 interfaces have been developed that expand the reach of the NJIIS statewide and increase the number of vaccine doses recorded in the system to 28,484,866. Interfaces with private insurance carriers, medical technology vendors and physician offices, as well as hospitals, local health departments and clinics contribute to populating the registry. Advance NJIIS Search Patient functionality, continued implementation of new interfaces with electronic medical record systems and the development of multistate data exchange documents to expand data sharing are a few of the many enhancements underway in the NJIS. All are designed to improve the patient flow of immunization information to providers for the sustaining of continuity of patient care and to increase immunization coverage rates statewide.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010
Annual Performance Objective				12.3	12.2	12	12
Annual Indicator	12.7	12.4	12.1	12.4	11.9	10.7	9.6
Numerator	2,192	2,216	2,184	2,233	2,131	1,916	1,721
Denominator	173,199	178,139	180,159	179,548	179,548	179,548	179,548
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	provisional

Notes - Provisional 2010 data is from a provisional EBC file. Census estimate for females 15-17 is from the Population Division, U.S. Census Bureau.
See Chart 4 Teen Births 15-17 attached to Section IV. A. Background and Overview.

a. Last Year's Accomplishments

The gradual decline in births to adolescents appears to be leveling in New Jersey. According to Guttmacher, although the number of live births to adolescents has declined in recent years, 20% of adolescents who give birth go on to have another child during adolescence. The majority of teen births are unplanned. A major barrier to improvement is that there are fewer healthcare providers of any type in the rural counties and public transportation is virtually nonexistent.

Eleven family planning agencies with 49 clinical sites provided comprehensive reproductive health services to more than 35,000 adolescents to assist the Title V program in meeting National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. Clinical services include physical assessment, laboratory testing and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities that deal with decision-making, value clarification and establishing linkages with youth-serving agencies were encouraged. Educational efforts are directed toward primary pregnancy prevention activities that encouraging family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. All family

planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle, injury prevention, drug, alcohol and tobacco prevention, as well as sexually transmitted disease (STD) and pregnancy prevention.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

The Region II Male Involvement Committee (Region II MAC) serves as a forum for the exchange of information and discussion of issues related to males and male services in Title X Family Planning, funded programs in Region II. After much review, this committee decided that male reproductive health providers needed some guidance in defining the scope of reproductive health services needed for males and to set standards for these services. A newly developed document "Guidelines for Male Sexual and Reproductive Health Services" is intended to be a resource used in the development of clinical services for male clients. Each item includes a statement of the "best practice" followed by a statement of evidence or rationale that supports the best practice and finishes with suggestions for methods to implement the recommendation. The committee recommends that the guide be used as a tool by an agency to develop an organizing structure, outlining male services to be included in their program. This document has been distributed to all Title X Family Planning funded programs and other agencies that have the knowledge and interest in issues related to male family planning services. A staff member of the Family Planning Program in Reproductive & Perinatal Health Services is a member of the Region II MAC.

	Pyramid Level of Service			
Activities	**DHC**	**ES**	**PBS**	**IB**
1. Family Planning Agencies providing comprehensive reproductive services.	X		X	
2. Collaborate with Dept. of Human Services Adolescent Pregnancy Prevention Program.				X
3. Adolescent Pregnancy Prevention Advisory Council				X
4. Community Partnership for Healthy Adolescents Grants				X
5. Adolescent Health Institute				X

b. Current Activities

Title X, NJ Family Planning agencies with 24 clinical sites continue to provide comprehensive reproductive health services to adolescents free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

In addressing the Teen Birth Rate, collaboration with the DHS, the DOE, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities for Teen Pregnancy Prevention Month (May).

Presently, this interdepartmental workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies. Also, intradepartmental planning is underway for the 8th Annual Day of Learning, which has recently broadened in scope to include peer leadership training on teen pregnancy and HIV/STD prevention. This program is now referred to as the Teen Prevention and Education Program, and a "Day of Learning" has been held annually in May to highlight pregnancy prevention month.

b. Plan for the Coming Year

Family Planning agencies will continue to provide comprehensive reproductive health services to clients each year to assist the Title V program to meet the National Performance Measure #8, reduction of birth to teens 15 - 17 years of age. MCH resources also continue to support a Young Fathers Program in Newark.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout New Jersey to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents. Nursing contact hours and certificates of professional development are awarded. The 13th Annual Adolescent Health Institute will be held on November 16th. Topics will include Office of Population Affairs Priorities, Preconceptual Care and Male Involvement in a Family Planning setting.

The Jewish Renaissance Foundation, in collaboration with the Central NJ Maternal Child and Health Consortium will continue "Comenzando Bien" a culturally appropriate, bilingual prenatal education curriculum created by the March of Dimes, at Perth Amboy High School. It was the belief of the Partnership that this initiative would provide important information and referral services to teen moms with the expectation of preventing subsequent births. This eight session initiative provides information about healthy pregnancies, creates a supportive environment that promotes healthy behaviors and empowers participants to become assertive and informed consumers of prenatal care services.

The Perth Amboy Plain Talk (PAPT) program will continue a collaboration with Planned Parenthood of Central New Jersey (PPCNJ) to provide comprehensive sex education in freshman health classes as well as having PPCNJ meet with the "Walkers and Talkers" to discuss any issues they may have and provide ongoing training on any topics they may feel they need to strengthen.

PAPT has also partnered with the nationally based organization, Advocates for Youth, to create a Youth Activist Network (YAN). YAN informs teens about resources and increases their knowledge and skills around sexual health information including safer sex, STI/HIV prevention, teen pregnancy, and access to contraception. YAN relates this information to their peers through "Pizza Protection Parties". YAN is also launching a Condom Availability Campaign to increase access to condoms for young people at nontraditional places, and a Text Messaging/New Media Campaign to educate peers on sexual health information and where they can access services in Perth Amboy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Annual Objective and Performance Data	2002 - 2003	2004 - 2005	2006 - 2007	2008 - 2009	2010-2011
Annual Performance Objective	43	44	45	46	46
Annual Indicator	42%	40	42	46%	46%
Numerator	803			1197	1,664
Denominator	1,883			2575	3,588
Is the Data Provisional or Final?	Final	Final	Final	Final	Final

2010: **Notes -** Beginning in 2007, two additional questions were asked on the parent/guardian recall survey pertaining to other dental/oral health issues. In 2009, a total of four additional questions were asked on the survey

Addition Survey Questions	2007	2009	2010-2011	2013	2015	2017	
Has Your Child Ever Had a Cavity or Filling	52%	51%	52%				
Has Your Child Had a	87%	91%	91%				

Dental Check-up in the Past Year?							
Has Your Child Ever Had a Toothache?	NA	22%	22%				
Do you Ever Feel Afraid or Nervous About Visiting the Dentist?	NA	22%	20%				
Does your child have dental insurance?			86%				

Data elicited from the 2010-2011 oral health survey found that 46% of students had a dental sealant on a permanent molar back tooth. The data is consistent from surveys conducted during previous school years, however it does note a slight increase in sealant usage.

a. Last Year's Accomplishments

The Children's Oral Health Program addresses the beginning of the life cycle and oral health through education for women during pregnancy, emphasizing the importance of dental visits, good oral hygiene practices and oral health issues relevant to pregnant women. For children and adolescents the Program's oral health curriculum supports learning that builds upon prior knowledge emphasizing tooth brushing with a fluoridated toothpaste, regular dental visits, smoking cessation and healthy food choices. In the area of children's oral health, support continues for statewide regional programs that implement a variety of age appropriate oral health education activities for school age children throughout the twenty one counties of the state. Programs include tooth brushing and flossing, use of fluoride as a preventive measure and the school based fluoride mouth rinse program, "Save Our Smiles" which reached approximately 24,000 children in 126 schools during the 2009-2010 school year. The annual mailing of the school newsletter "Miles of Smiles" was mailed to over 3,500 school nurses. This annual publication addresses' timely oral health topics of interest, promotes the importance of good oral hygiene practices. Oral health education targeted to school faculty is also included so the school nurse may promote good oral health throughout the school setting.

Collaborative partnerships continue and include the "Homeless Shelter Project Initiative" conducted since 2008 in collaboration with the NJ Dental Hygiene Association that reached over 1,000 homeless families with children to date, the "Service Learning Collaborative Initiative in conjunction with the Dental Hygiene Program of Burlington County College and a local FQHC, "Protecting Oral Health from Pregnancy to Puberty" Initiative began in 2008 to improve the oral health of pregnant women and to promote good oral hygiene practices for their baby. A variety of newsletters are developed and distributed and include "Oral Hygiene for Children with Special Health Care Needs," WIC and Oral Health,"

Dr. Kupiec-Sce of the Children's Oral Health Program was also invited to participate in and prepare a "Best Practices Collection" of all initiatives undertaken by the Program. New Jersey was one of a very few select states invited to participate by the Association of State and Territorial Dental Directors in 2009 and will prepare a revised collection in 2011.

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Federally Qualified Health Center (FQHC) Expansion	X			X
2. Physician/Dentist Loan Redemption Program				X
3. Regional Oral Health Promotion Programs			X	X
4. Give Kids a Smile Day			X	X
5. ”Save Our Smiles”,” school based voluntary Fluoride Mouthrinse Program			X	X

b. Current Activities

The Children's Oral Health Program administers the school-based voluntary weekly "Save Our Smiles" fluoride mouth rinse (FMR) program. The 32-week program represents an active intervention in the Children's Oral Health Program to reduce tooth decay in elementary school children. The FMR program targets schools in communities with non-fluoridated water systems and where the water is not optimally fluoridated. At the present time, the program provides fluoride mouth rinse program using either a mix and pump method or a unit dose system with schools that choose the unit dose system paying the cost difference.

Regional program staffs promote the use of mouth guards for protection from oral injury in school and community-based education programs. In addition, the "Dental Emergency Guide" poster was developed and distributed to all school nurses, high school athletic directors and summer camp directors throughout the State to assist staff in the treatment of minor dental emergencies and oral trauma.

During Children's Dental Health Month/February 2011, "Sugarless Day to Prevent Tooth Decay 2011" was conducted in a few select schools Statewide. These events which engaged students, family members and the community in education about good oral hygiene and healthy food choices received community support through local press and media coverage. Due to the success of the events, schools requested an expansion of this Initiative in 2012.

Recognizing that early prevention is necessary for optimal oral health and that pregnancy is an ideal time to educate women about good oral health practices for themselves and their children, the "Pregnancy and Oral Health Initiative" which evolved into Project" REACH has been established.

Dental initiatives undertaken by Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) to promote utilization of dental services include:

Oral Health Stuffer – "Keeping Your Child's Smile Healthy" was updated in 2012 to indicate age referral to dentist should occur by the age of 1. Language was revised to provide information in layman terms while educating the consumer on dental terms. Stuffer is provided in mailings to those in Fee For Service (FFS), was provided to HMOs for distribution to their members and to WIC for distribution to their clients. It is posted on the Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) and on the websites for American Academy of Pediatricians and Center for Health Care Strategies.

Dental Advisory Council - meets three times a year, but is also convened for special projects. The council was established in 2005 by the Division of Medical Assistance and Health Services (DMAHS) and works to bolster communication with the dental community and has representation from the NJFC HMOs, UMDNJ – Dental School, Federally Qualified Health Centers, NJ State Board of Dentistry, NJ Dental Association, the dental specialties and dentists from private offices. The Council's activities may include study of priorities, standard of care, quality measures, barriers to care and access strategies, utilization strategies, program benefits and cost of care. The council prepares specific recommendations to DMAHS and interprets goals and policies for professional and community interest groups.

Medical/Dental Directors Meetings – These meetings occur two to three times a year and are a forum to allow DMAHS to communicate directly with the medical and dental directors for the NJFC-MCOs on interpretations, expectations or revisions to policies as set forth in New Jersey Administrative Code (N.J.A.C.) or the HMO Contract.

The Periodicity of Dental Services for Children in the NJFC Programs titled "When Children in NJ Family/Care Should See the Dentist" was revised in 2012 to be consumer friendly. It was updated to indicate referral to a dentist is required by age one, that a trained medical professional could also provide fluoride varnish and emphasized that needed dental treatment should be provided to primary or "baby" and permanent teeth. This information is posted on the Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) and on the websites for American Academy of Pediatricians and Center for Health Care Strategies.

Oral Health Stuffer – "Keeping Your Child's Smile Healthy" is informational on what a caregiver can do to keep a child's smile healthy beginning with the eruption of the first tooth. The goal is educate families that you cannot have good overall health without good oral health and encourages them to establish a dental home early in a child's life so that they can begin preventive dental services and learn good oral health habits at a young age.

NJ Smiles Directory of Dentist Seeing Young Children – this directory is a listing by county of dentists seeing young children. It includes their HMO or Fee for Service participation, if they are handicapped accessible and if they provide dental care to patients with special healthcare needs. It is also available as fact sheet by county with this version having the periodicity table and oral health educational materials included. It is updated annually and will be posted on the Department of Human Services website under the Division of Medical Assistance and Health Services (DMAHS) and is currently on the websites for American Academy of Pediatricians and Center for Health Care Strategies.

Insure Kids Now Website – Information on the dental benefits available to children enrolled with NJFC/Medicaid is posted on this site along with the names and contact information for dentist seeing children by HMO and State Fee for Service.

Age for First Dental Visit – Contract change for NJFC MCOs effective July 1, 2010 indicates that first dental visit can be provided as early as the eruption of the first tooth and is required by age one. Preventive Services by Non-Dental Health Care Providers – Contract change for NJFC MCOs effective January 1, 2012 allows a trained medical professional to provide risk assessment, fluoride varnish and direct referral to the dentist for young children through the age of five.

American Academy of Pediatricians (AAP) Oral Health Initiative – DMAHS has partnered with the AAP on this initiative to identify and establish strategies to educate medical providers on the importance of early intervention with an age one dental visit, oral health education, fluoride varnish, risk assessment and dental referral, to educate parents and communities on the importance of good oral health, healthy habits, the need for early and periodic dental visit and treatment and to identify and develop financial strategies to providers for use by payers of services.

Give Kids A Smile – Each year DMAHS collaborates with the NJ Dental Association to provide volunteers that assist families with NJFC/Medicaid in locating a dentist and to provide enrollment information or location of clinics for those without dental insurance.

c. Plan for the Coming Year

During the school year 2011-2012, the "Sugarless Day to Prevent Tooth Decay" initiative will be expanded to include the 21 counties of the State. In addition, the NJ Homeless Shelter Collaboration Project between the Children's Oral Health Program and the NJ Dental Hygiene Association will continue and target 5 shelters in the State by providing oral health education and hygiene instruction to children along with oral care resources and personal care items provided by the NJ Dental Hygienists Association. The Pregnancy and Oral Health Initiative Collaboration Project between the Children's Oral Health Program and a federally qualified health center that has evolved into Project: REACH will be expanded to other federally qualified health centers utilizing the train the trainer model to educate obstetricians and staff about the importance of oral health for pregnant women. The Service Learning Project between the Children's Oral Health Program and Burlington County College School of Dental Hygiene will again take place. Education efforts conducted through county wide library systems in the central region of the State will be part of "Tooth Tales," an interactive reading program targeting pre-K to grade 3 children and families and educating them about good oral health.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Annual Objective and Performance Data	2003	2004	2005	2006	2007	2008	2009
Annual Performance Objective	1.9	1.7	1.6	1.6	1.5	1.5	1.4
Annual Indicator	2.0	1.5960	1.3233	1.2223	1.7071	0.95*	0.83*
Numerator	35	28	23	21	29	16	14
Denominator	1,769,074	1,761,746	1,740,943	1,718,277	1,701,841	1,692,062	1,689,425
Is the Data Provisional or Final?		Final	Final	Final	Final	Final	Final

Notes - Data source - CDC National Center for Injury Prevention and Control website www.cdc.gov/ncipc/wisqars/. * Rates based on 20 or fewer deaths may be unstable.

a. Last Year's Accomplishments

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes has declined since 1997 both in New Jersey and in the United States.

In 2008 the NJDHSS Office of Injury Surveillance and Prevention (OISP) convened a panel of injury prevention experts to provide recommendations in key injury areas which included motor vehicle crashes and unintentional childhood injuries. Recommendations are included in the August 2008 report - Preventing Injury in New Jersey: Priorities for Action.

The main factors that contribute to motor vehicle occupant fatalities in NJ are speed, alcohol, and failure to use restraint options including infant seats, booster seats, and seatbelts. Proper use of occupant restraints plays an important role in reducing fatalities and serious injuries among children in the event of a crash. Seatbelt use in NJ is above the national average, and 2007 data from the NJ Division of Highway Traffic Safety estimated the usage rate at over 91%. A recent “Click it or Ticket” mobilization effort combining education and enforcement resulted in an increase in seat belt use among motorists.

Motor vehicle accidents remain the leading cause of death for teenagers. Teenage drivers are one of the top causes of car accidents. Kyleigh’s Law took effect in May 2010 and required probationary drivers, ages 16 and 21, to affix a $4 pair of red fluorescent decals on their front and rear license plates during a one-year provisional license period. The decals were intended to make it easier for police to identify first-time drivers on the road and ticket them if they violate the provision of the New Jersey’s graduated licensing restrictions which prohibit teens from driving between 11 p.m. to 5 a.m., limit car occupants to one other underage passenger, and prohibit any use of “interactive wireless communication.” Kyleigh’s law was unanimously upheld by a three-judge panel in February 2011.

The main goal of the NJ Safe Routes to School (SRTS) program is to assist communities in developing and implementing projects and programs that enable and encourage safe walking and bicycling trips to school. Since the program was initiated, NJDOT has awarded 104 grants worth $13.5 million to local projects affecting 192 schools in 83 communities. These grants have funded both infrastructure projects, such as sidewalks, crosswalks and bike paths, as well as non-infrastructure projects, like education, enforcement and encouragement programs.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Child Care Initiative safety focus NJ Safe Routes to School (SRTS) program			X	X
2. Childhood Lead Poisoning Prevention Project's safety focus				X
3.EMS “Anticipating the Unexpected…” training curriculum				X
4. Law and Public Safety awareness and education projects				X
5. Division of Highway Safety’s NJ Traffic Safety curriculum				X
6. Safe Kids New Jersey, in school project				X

b. Current Activities

The Childhood Lead Poisoning Prevention Projects (CLPPP), provides lead-focused case management and instructs families in child safety, including the use of infant car seats and child restraint systems. This type of instruction contributes to the progress being made on unintentional injury prevention activities, even though it is not specifically focused on deaths due to motor vehicle crashes.

The Healthy Child Care New Jersey (HCCNJ) Initiative continues to emphasize safety at home and in the child care center, and has collaborated with the state's Emergency Medical Services (EMS) for Children program on the training curriculum "Anticipating the Unexpected: Planning for Emergencies in Child Care Setting" (formerly titled "Anticipating the Unexpected in Child Care Settings". The HCCNJ Initiative also partners with Safe Kids Programs whenever possible throughout the year. Safe Kids offers a wide variety of programs to improve the health and well being of New Jersey youth.

Motor vehicle accidents remain the leading cause of death for teenagers. Teenage drivers are one of the top causes of car accidents. Kyleigh's law was unanimously upheld by a three-judge panel in February 2011.

New Jersey's Emergency Medical Services (EMS) for Children program continues to provide training using the curriculum "Anticipating the Unexpected: Planning for Emergencies in Child Care Setting."

Law and Public Safety (LPS) funds numerous awareness and education projects on the county and municipal level throughout the State with the goal of decreasing crash experience, injury and death in this age group. Projects primarily focus on pedestrian, bicycle and child passenger safety. More information is available on the website: www.njsaferoads.com.

NJ Parent Link (www.njparentlink.nj.gov) is the State of New Jersey's web-based Early Childhood, Parenting and Professional Resource Center. In the section titled "Child and Family Safety", there are two links: *Pedestrian and Bicycle Safety* and *Safety: Child Safety Seats & Seat Belts* for more information. In the section "Community Resources" there is a link to *Safe Kids New Jersey*. Safe Kids New Jersey (SKNJ) is the lead organization on preventing motor vehicle deaths in New Jersey. SKNJ focuses on five areas of injuries for children from birth to 14 years old and offers a wide variety of programs to improve the health and well being of New Jersey youth.

DOT has streamlined the funding process and is getting programs out to the communities who need them more quickly. Applications were due at the end of December 2011 for FY 2012 SRTS Infrastructure Grant program to build projects within two miles of an elementary school. Schools and municipalities with special needs were also able to apply for funds to pay for the design of these projects.

Non-infrastructure projects are being implemented through the NJ SRTS Resource Center, a pilot program at the Alan M. Voorhees Transportation Center at Rutgers University, and a partnership with New Jersey's eight Transportation Management Associations (TMAs): Cross County Connection, Greater Mercer TMA, Hudson TMA, Hunterdon Area Regional Transport, Keep Middlesex Moving, Meadowlink, Ridewise and TransOptions. TMA staff provide technical assistance directly to communities and all municipalities and K-8 schools are eligible to enroll as SRTS partners and receive free SRTS program related services. TMAs have assisted with International Walk to School Day in October 2011 and will take part in the first Walk and Bike to School Day on May 25th, 2012.

c. Plan for the Coming Year

The Healthy Child Care New Jersey Initiative State's Emergency Medical Services for Children program will continue to emphasize safety at home and in the child care center, and has collaborated with using the state's Emergency Medical Services for Children program to develop a training curriculum entitled " " Anticipating the Unexpected: Planning for Emergencies in Child Care Settings". This curriculum has is expected to be provided to child care providers in a variety of venues.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Annual Objective and Performance Data	2002	2003	2004	2005	2006	2007	2008	2009
Annual Performance Objective						42	43	44
Annual Indicator	39.0	44.4	44.5	37.3	37.3	42.3		
Numerator								
Denominator								
Is the Data Provisional or Final?	final	final	final	final	final	prov		

Notes - Source – the CDC's National Immunization Survey.
http://www.cdc.gov/breastfeeding/data/NIS_data/ 2007 – 422002 – 39.0 +/- 5.8 %
2003 – 44.4 +/- 5.7 %
2004 - 44.5 +/- 5.4 %
2005 – 37.3 +/- 6.27.4 %

a. Last Year's Accomplishments

Two hospitals have achieved Baby Friendly hospital status.

In Healthy New Jersey 2010, there are two objectives for breastfeeding: 1) to increase the proportion of mothers who breastfeed their babies at hospital discharge to at least 75.0 percent and 2) to increase the proportion of breastfed infants who are breastfed exclusively at hospital discharge to 90.0 percent. The national breastfeeding objectives are for 75% of mothers to breastfeed in the early postpartum period, for 50% of new mothers to continue breastfeeding until their infants are six months old, for 25% to breastfeed until one year, for 40% to exclusively breastfeed through three months, and for 17% to breastfeed exclusively through six months.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in New Jersey continued to decline in 2007 (See Chart 9 attached to Table of Contents), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2007, exclusive breastfeeding at hospital discharge statewide was 35.7% while any breastfeeding (exclusive and combination feeding) was 70.5%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (85.7%) while Black non-Hispanic women were least likely to breastfeed (53.3%). White non-Hispanic and Hispanic women initiated breastfeeding at 69.9% and 75.2% respectively.

The exclusive rates were 47.5% for White non-Hispanic women, 36.1% for Asian non-Hispanic women, 22.8% for Hispanic women, and 21.0% for Black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

Close collaboration between Maternal and Child Health Services (MCHS) and WIC Services (WIC) is ongoing. Both programs have an interest in breastfeeding protection, promotion and support and have similar constituencies. The CDC Guide to Breastfeeding Interventions was sent to all the delivery hospitals in the State.

In 2008, FHS prepared a report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report (posted at NJ.gov/health/fhs/professional/breastfeeding_report.shtml), which is endorsed by the State chapter of the American Academy of Pediatrics (NJ-AAP) and the New Jersey Breastfeeding Task

Force. The goal of the report is to present breastfeeding initiation as a quality of care issue, and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Professional outreach and education through MCH Consortia				X
2. Surveillance from the Electronic Birth Certificate (EBC) and Breastfeeding and New Jersey Maternity Hospital Report			X	X
3. Supporting the development of breastfeeding friendly policies in child care settings				X
4. Surveillance of breastfeeding through the NJ PRAMS survey			X	X
5. Baby Friendly Hospital Initiative				X

b. Current Activities

Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to eight local WIC agencies and three MCH Consortia, which provide services to ten local WIC agencies. WIC lactation consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

c. Plan for the Coming Year

The report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report, will be updated with 2011 data from New Jersey's delivery facilities. Greater emphasis will be placed on exclusive breastfeeding, both in WIC and at hospitals. There will be strong advocacy for hospitals to adopt the Perinatal Care core measure set, which includes a measure for exclusive breast milk feeding and for hospitals to implement evidence-based best practices for infant feeding. The United States Breastfeeding Committee publication, Implementing the Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding, will be recommended to the State's delivery facilities as a tool to help them implement the measure on exclusive breast milk feeding.

Strategies to promote breastfeeding will be addressed as part of the Shaping NJ Partnership to prevent childhood obesity. The ONF received a NPAO grant from the CDC to coordinate Nutrition, Physical Activity and Obesity strategies. One of the six target behaviors is to increase breastfeeding duration and exclusivity. A work group of the Shaping NJ Partnership is working on promoting exclusive breastfeeding through changing hospital policies and practices. ONF is promoting exclusive breastfeeding for new mothers in ten NJ maternity hospitals thru $10,000 grants to support the Baby Friendly Hospital Initiative.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective	99	99	99	99	99	99	99
Annual Indicator	98.8	99.2	99.3	99.6	99.7	99.8	99.8
Numerator	108,561	110,070	111,006	108,119	105,847	102,712	99,037
Denominator	109,902	110,903	111,841	108,514	106,185	102,930	99,228
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	Provisional

Notes – Provisional 2011 data from the Newborn Hearing Screening Program is based on the Electronic Birth Certificate which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

a. Last Year's Accomplishments

In 2011, 99.8% of infants were screened prior to discharge. Rates for children receiving follow-up after referring on inpatient screening continue to rise, but remain an area requiring improvement.

The Early Hearing Detection and Intervention (EHDI) reporting module in the NJ Immunization Information System (NJIIS) is utilized by audiologists and other practitioners, who are conducting hearing follow-up, to report outpatient exams. NJ-EHDI receives approximately 86% of reports through this Web-based application and thirty-two new users were trained during 2011.

The program had an exhibit table at the 2011 annual meeting of the NJ-AAP which was attended by 300 physicians, and did site visits to two pediatrician offices to review EHDI requirements. EHDI staff also gave a presentation to members of the New Jersey Medical Home Resource Team for CYSHCN. The EHDI audiologist presented at a statewide conference for audiologists with 65 attendees.

The EHDI program held regional meetings for hospital EHDI staff in September and October 2011 at northern, central, and southern locations in the State, with each hospital sending at least one representative to one of the three meetings. The program partnered with other service units to include presentations on biochemical and pulse oximetry screening and autism and birth defects reporting. The meetings were held on September 19 with 44 attendees, September 23 with 70 attendees and October 19 with 139 attendees. Individual teleconferences with each hospital began on September 28, 2010 and were completed for 46 hospitals by December 21st, with 6 final hospital calls postponed into 2012.

The biennial Family Learning Conference for families with children who are deaf or hard of hearing was held on April 16, 2011 for 175 attendees. This conference affords parents of children with hearing loss the opportunity to meet deaf and hard of hearing adults, network with other parents, and most importantly, to hear from children themselves about growing up with a hearing loss. Since the Family Learning Conference is a family driven event, normally hearing siblings are also invited.

In April 2011, the NJ Pediatric Hearing Health Care Directory was updated and improved as a searchable on-line directory with the ability to map facility locations and obtain driving directions. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services.

The EHDI program collaborated with staff from the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS) granting NJIIS-EHDI module access to DCF staff nurses who are responsible for health care for children in foster care placement. In April 2011, 235 DYFS staff members attended one of 4 webinars that provided information about the EHDI module and new hires watch a recorded version of the webinar. This effort will help to ensure children in foster care receive appropriate hearing follow-up services since this population has been much more likely to be lost to follow-up.

The EHDI Program continued a project begun in October 2009, where HRSA funding allows case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up, the level of effort put into this by each hospital and the success of their efforts varies widely. This program provides supplemental contacts to compliment the hospital’s outreach efforts. During 2011, the case managers contacted 1,117 families, contributing significantly to the improvement in follow-up rates.

The EHDI program began efforts to improve the documentation of newborn hearing screening for babies that are home deliveries. In 2010, only 23 of the 177 home deliveries in New Jersey had hearing screening reported to the EHDI program. The EHDI program met with midwives to develop an

information sheet for midwives and parents that provides information on hearing screening and also other relevant DHSS requirements such as biochemical screening and how to obtain a birth certificate.

Two additional FQHCs purchased equipment to conduct re-screening to supplement the three centers that began this service in 2010. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational outreach to practitioners (audiologists, pediatricians, otolaryngologists, etc.).				X
2. Hospital level surveillance reports.			X	
3. Increase in follow up and reporting for those who are not screened while inpatient or refer on initial screening.	X	X		

b. Current Activities

To begin using telepractice to benefit children with hearing loss, the EHDI program funded one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to hire two part-time consultants. They will use laptops with web-cameras to participate in initial early intervention family meetings via remote access. The consultants are currently developing resource materials and developing the referral process.

The program is planning a webinar for SCHS case managers, EI staff, audiologists and physicians on the impact of unilateral hearing loss. These children are less likely to be enrolled in EI services, possibly due to an erroneous assumption by providers that these children are not eligible for services or would not benefit from services.

Another webinar under development is an EHDI overview for hospital staff responsible for newborn hearing screening. Due to the frequent changes in staff in some hospitals, a recorded webinar will be available to explain the EHDI program's regulatory obligations to ensure and improve hospital compliance.

The EHDI program recently is working with staff from the Communicable Disease Service division to notify the EHDI program of children diagnosed with meningitis. The goal of this collaboration is to ensure that children with hearing loss caused by meningitis receive timely referral for audiology and otolaryngology services, since a delay in can impair the ability for the child to benefit from cochlear implantation.

c. Plan for the Coming Year

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent semi-annually, and in intervening quarters, hospital contacts receive a list of children that are still in need of follow-up after missed or referred inpatient hearing screening.

EHDI staff will provide educational presentations to pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention Service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses Webinars, to make educational outreach efforts more accessible to the target audiences, to decrease staff travel time, and to improve efficiency while decreasing costs.

The parent support services provided through the REIC will continue to develop and expand through the coming year. As contacts with families are implemented the program will adjust the resources and scripts

used for the contact and identify weaknesses in the EHDI process that are identified through individual conversations with families.

The program will participate in a National Initiative for Children's Healthcare Quality Learning Collaborative to identify small tests of change to improve hearing screening and follow-up.

The program will expand on efforts to improve screening of babies delivered at home by sending a letter to families of infants born at home, encouraging them to bring their child in for screening.

The EHDI program will begin sending follow-up letters to the primary care provider of infants that are in need of additional follow-up to prompt these providers to refer families for audiologic evaluation.

The EHDI program will be reviewing the interoperability of the EHDI information system and looking for opportunities to utilize Electronic Health Record data to decrease the need for duplicate data entry. As the Bureau of Vital Statistics and Registration begins to implement a new Electronic Birth Registration System, the EHDI program will work with the program to ensure the continued capture of inpatient hearing screening results and risk indicators through this system.

Performance Measure 13: *Percent of children without health insurance.*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010
Annual Performance Objective					13	13	13
Annual Indicator	11.7	11.3	13.6	13.0	13.0		
Numerator	269,256	258,536	299,274	288,300	288,300		
Denominator	2,299,330	2,292,031					
Is the Data Provisional or Final?	Final	Final	Final	Final	Final		

Notes - Source: the Annual Social and Economic Supplement (ASEC) of the Current population Survey (CPS), which is conducted by the Bureau of the Census for the Bureau of Labor Statistics. The age group is children 0-18 years old.
http://nj.gov/health/chs/documents/hic00_08.pdf

a. Last Year's Accomplishments

Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, NJ and the Federal government have joined as partners in NJ FamilyCare (formerly NJ KidCare). NJ FamilyCare, administered by the NJ Department of Human Services, started in 1998.

In July 2008 a health care reform bill was signed into law expanding the NJ FamilyCare Program and allowing NJ to reinstitute enrolling parents up to 200% of poverty. The bill also contains a KidsFirst mandate requiring that all children (18-years and younger) have health insurance as of July 2009. Beginning in the 2008 tax year, individuals who file a NJ income tax return must indicate whether their dependents have health insurance and if they do not they will be mailed letters regarding health insurance options. Additionally, there are a number of market reforms in the bill including the introduction of age as a rating factor in NJ's individual insurance market.

As of February 2009, there were 556,000 children enrolled in the expanded NJ FamilyCare initiative and 212,000 parents enrolled in the NJ FamilyCare program. In the course of developing NJ FamilyCare, the State learned that many poor children who are eligible for free health insurance under the State's Medicaid program are not enrolled. The aggressive marketing and outreach programs designed to enroll children in NJ FamilyCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ FamilyCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. Of the approximately four percent of uninsured children who do not qualify for NJ FamilyCare or Medicaid, many experience temporary gaps in insurance coverage, usually as a result of changes in parental employment. If employer-sponsored health insurance continues to decline, NJ FamilyCare will not be able to reduce the overall number of uninsured children in the State. Unfortunately, the percentage of uninsured children in New Jersey has increased from 8.2% in 1999 to 13.0% in 2008.

The NJ Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., NJ Policy Perspective, Association for Children of NJ (ACNJ), Legal Services of NJ, the NJDHSS, NJDHS, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, the Office of the Child Advocate and a public

member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings.

Data from Rutgers Center for State Health Policy indicate that 293,790 NJ children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07. Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid. According to information from DHS, Division of Family Development (DFD), the recession has caused a 50 percent increase in the number of individuals requesting assistance directly from the County Welfare Agencies from December 2007 to December 2008. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in NJ will continue to grow.

Due to state budget cuts, Reproductive and Perinatal Health Services no longer funds the Healthy Mothers, Healthy Babies (HMHB) Coalitions or the Black Infant Mortality Reduction (BIMR) projects which facilitated the FamilyCare enrollment of children whose mothers were served by these projects.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment Plan				X
2. MOU with NJ FamilyCare				X
3. KidsFirst mandate requiring all children have health insurance				X
4. Express Lane Application Flyer (May 2010)				X

b. Current Activities

NJ has one of the nation's most generous programs, available to families of four earning up to $77,175. There is no cost for many families. For those with higher incomes, there is a sliding scale for small co-payments and monthly premiums. For families who earn too much to qualify for NJ FamilyCare, NJ offers NJ FamilyCare Advantage, www.horizonNJhealth.com. NJ has simplified enrollment and renewal and reduced paperwork with the use of an express lane application. New Jersey's schools, hospitals, state officials and community agencies have been working together to enroll more children to be insured. Health Service grants funded by Reproductive and Perinatal Health services will continue to require agencies to outreach and facilitate enrollment of potentially eligible children. Outreach to pregnant women will include facilitating access to FamilyCare enrollment to ensure a smooth transition to a pediatric medical home for infants served by the infant mortality reduction projects.

NJ developed an Express Lane Eligibility program to help find and enroll uninsured children in NJ FamilyCare and Medicaid. In addition to the state's Express Lane effort that uses tax forms, NJ is also engaged in a pilot project to partner with 9 school districts and conduct Express Lane Eligibility based on eligibility for the school lunch program.

Based on the Work Group's research and discussion, barriers and recommendations were identified. A report, NJ FamilyCare Outreach, Enrollment and Retention Report May 2009, was produced which identifies findings and recommendations to help meet goals of the Reform Act.

Reproductive and Perinatal Health Services continues to work with the Access to Prenatal Care Initiative grantees, Healthy Start Projects and Black Infant Mortality Reduction projects to facilitate enrollment of children whose mothers are served by the projects.

Atlantic City, Paterson, and Essex County HMHB coalitions have made FamilyCare enrollment one of their priority areas as an access to care issue. Outreach staff assists clients with accessing the system and completing the enrollment process.

Due to state budget cuts, Reproductive and Perinatal Health Services no longer funds the Healthy Mothers, Healthy Babies (HMHB) Coalitions or the Black Infant Mortality Reduction (BIMR) projects which facilitated the FamilyCare enrollment of children whose mothers were served by these projects.

c. Plan for the Coming Year

Recommendations to reduce barriers to health insurance enrollment for children and reduce the number of uninsured children are included in the Work Groups report - NJ FamilyCare Outreach, Enrollment and Retention Report May 2009 (http://www.acnj.org/admin.asp?uri=2081&action=15&di=1442&ext=pdf&view=yes).

All relevant departments, serving children and families, are willing to work cooperatively to reduce unnecessary barriers to coverage for eligible children. New Jersey has made some progress in capitalizing on technology but can do more to achieve efficient use of online applications and other technology. New Jersey also can do more in helping families renew their child's coverage so children are covered for as long as they are qualified and have consistent access to health care. CSH will help spread the word by encouraging parents, teachers, doctors, school nurses and others working with families to visit www.njfamilycare.org or call 1-800-701-0710 to find out if their children are eligible. NJ FamilyCare fact sheets are also available in 15 languages from the NJ FamilyCare website. Federal health insurance reforms and expansion of Medicaid and SCHIP will also positively impact children and families in need of health care services.

Health Service grants funded by Reproductive and Perinatal Health services will continue to require agencies to outreach and facilitate enrollment of potentially eligible children. Outreach to pregnant women will include facilitating access to FamilyCare enrollment to ensure a smooth transition to a pediatric medical home for infants served by the infant mortality reduction projects.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective						34	33
Annual Indicator	39.8	39.1	35.6	35.4	35.9	34.3	
Numerator							
Denominator	60981	61,327	61,876	68,163	75,191	78,181	
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	

Notes - Data from the 2010 WIC Pediatric Nutrition Surveillance System, Table 12C

a. Last Year's Accomplishments

New Jersey has one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent according to the 2009 WIC Pediatric Nutrition Surveillance System.

The 2008 CDC five-year NPAO cooperative agreement award to the DHSS Office of Nutrition and Fitness (ONF) established the ShapingNJ Partnership to enlist the commitment of diverse partners from across the state to develop a NJ NPAO State Plan. Partners worked in seven workgroups: physical activity; fruit and vegetable; breastfeeding initiation, duration and exclusivity; TV viewing; energy dense foods and sugar sweetened beverages; Executive and Sustainability Committee; and, Surveillance and Evaluation. ShapingNJ workgroups were directed to 1) focus on policy and environmental change strategies; 2) target resources to those at greatest risk for obesity and other chronic diseases; 3) promote and utilize evidence-based strategies among all partners; and, 4) establish priority populations (at-risk populations in low-income and minority communities) and strategies, identify available data sources and gaps, and set measurable program objectives.

In 2009, NJ Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program introduced a new food package. Changes in the WIC food packages align with Dietary Guidelines for Americans and current AAP infant feeding practice guidelines, promote breastfeeding, provide a wider variety of food, and allow greater flexibility in prescribing food packages to accommodate participants with cultural food preferences. The NPAO behavioral strategies of increasing breastfeeding, physical activity and the consumption of fruits and vegetables; and decreasing sugar-sweetened beverages, fatty foods and TV viewing – are addressed at WIC individual or secondary contact sessions.

WIC held Statewide Grow and Glow trainings to promote breastfeeding and teamwork at WIC state agencies. The goal was to increase the awareness of breastfeeding services available as well as promote a better understanding of staff roles at WIC to better support breastfeeding.

Through September 30, 2011 a pilot project was conducted in collaboration with the Department of Human Services - Division of Family Development, the Office of Nutrition & Fitness - Department of Health & Senior Services and the NJ Association for Child Care Resource & Referral Agencies. Five child care centers in each of NJ's 21 counties (n = 105) participated in an evidence based project (NAP SACC – Nutrition and Physical Activity Self Assessment for Child Care) aimed at preventing obesity by improving policies and practices in the areas of nutrition, physical activity, screen limitations and breastfeeding support. At the same time, based on NJ childhood obesity data and poor ratings of existing regulations related to obesity prevention, new recommendations were proposed. These proposed regulations were determined though 25 county focus groups and subsequently submitted to the Office of Licensing for review and consideration.

	Pyramid Level of Service			
Activities	**DHC**	**ES**	**PBS**	**IB**
1. Office of Nutrition and Fitness, CDC NPAO cooperative agreement and establishment of the Shaping NJ Partnership				X
2. New WIC food package implemented				
3. Child care regulations revised, field tested (focus groups) and proposed to the Department of Children & Families - Office of Licensing				X
4. Child Care Best Practices Tool Kit (in development)				X
5. Workshop trainings for child care providers at annual conferences				
6. Breast Feeding Hospital Initiative Forum (BFHI)				X
7. Baby Friendly Hospital new designations				X

b. Current Activities

ShapingNJ enlisted the commitment of diverse partners from across the state to address the obesity epidemic and develop a NJ NPAO State Plan. Partners worked in seven workgroups: physical activity; fruit and vegetable; breastfeeding initiation, duration and exclusivity; TV viewing; energy dense foods and sugar sweetened beverages; Executive and Sustainability Committee; and, Surveillance and Evaluation. ShapingNJ workgroups were directed to 1) focus on policy and environmental change strategies; 2) target resources to those at greatest risk for obesity and other chronic diseases; 3) promote and utilize evidence-based strategies among all partners; and, 4) establish priority populations and strategies, identify available data sources and gaps, and set measurable program objectives.

c. Plan for the Coming Year

In 2011, the CDC NPAO cooperative agreement is concentrating its focus on five settings: schools, communities, child care centers, worksites and health care facilities. The ShapingNJ Partnership currently has over 100 health, education, parks and recreation, agriculture and business organizations.

In January 2010, the state passed a law requiring food chains with 20 or more locations nationally to provide calorie counts for food and beverages. The law will take effect in 2011. New Jersey is one of 19 states that have stricter nutritional standards for school lunches, breakfasts and snacks than mandated by federal U.S. Department of Agriculture requirements.

The ShapingNJ Partnership recently received additional federal funding for a two-year obesity prevention initiative, which will be implemented as part of the partnership's strategic plan. For the school setting, Adolescent Health grantees will implement CDC's Coordinated School Health (CSH) model by creating a school health team of diverse composition; analyzing the strengths and weaknesses of existing school health policies, curricula, programs and services using CDC's self assessment tool: the School Health Index (SHI); and, developing an action plan that prioritizes areas for improvement. For the hospital setting, exclusive breastfeeding will be promoted through grants to support the Baby Friendly Hospital Initiative to change hospital breastfeeding policies and practices.

c. Plan for the Coming Year

Through the Baby Friendly (BF) Hospital initiative, two NJ hospitals are BF: SJH Elmer Hospital (South Jersey Healthcare) and Capital Health Medical Center – Hopewell.

Exclusive breastfeeding is being promoted through grants to support the Baby Friendly Hospital Initiative to change hospital breastfeeding policies and practices.

The ***ShapingNJ*** child care workgroup has collaborated on a number of systems efforts. The Office of Licensing posted the revised NJ Manual of Child Care Requirements on February 21, 2012 for a 60 day public comment period ending April 21, 2012. Efforts are underway to engage partners in submitting comments. Simultaneously the workgroup is developing a user friendly child care tool kit, designed to be web-based, to accelerate changes in early care and education. Child care partners will present subject specific topics at annual child care conferences this year.

NJWIC continues to promote physical activity and plans to develop a new lesson on their NJ WIConline.org website for WIC participants to complete their secondary nutrition education contact.

Moving forward, the ***ShapingNJ*** child care workgroup will be tracking the status of proposed child care regulations and conduct outreach on the resulting new regulations. Efforts will be made to: 1) disseminate the child care tool kit through partner networks; 2) highlight 'spotlight' topics on websites & newsletters; 3) share resources through existing NJ Association of Child Care Resource & Referral Agencies training calendars; 4) target information on best practices to parents; and 5) coordinate messages with WIC and the ***ShapingNJ*** healthcare workgroup. The ***ShapingNJ*** child care workgroup anticipates convening a group of state agencies involved in child care, identifying points of integration between pre-school core standards and the tool kit and, exploring opportunities for connecting pre-service early childhood. This work will be shared with partners at the county level through the Office of Local Public Health for more rapid dissemination.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010
Annual Performance Objective					7.0	7.0	6.8
Annual Indicator	7.9	6.7	5.7	6.2	6.8		
Numerator							
Denominator							
Is the Data Provisional or Final?	final	final	final	final	final		

Notes - Data is from the NJ PRAMS Survey and the CDC Ponder System.
See NJ PRAMS Brief on Smoking and Pregnancy in New Jersey at
http://www.state.nj.us/health/fhs/documents/brief_smoking_prevalence.pdf

a. Last Year's Accomplishments

Initiated in 2001 with funding from the NJDHSS-Comprehensive Tobacco Control Program, Mom's Quit Connection (MQC) is New Jersey's maternal child health smoking cessation program. MQC receives fax referrals via healthcare providers, community and social services agencies, and a toll free number is also available for self referral. MQC's trained Tobacco Dependence Specialists utilize a proactive behavior modification model, offering face-to-face individual counseling at the referring health care facility, on site group counseling or telephone counseling to assist clients in developing a customized quit plan. MQC receives between 400 and 500 referrals annually; these referred clients then receive self help materials or choose to enter case management for individualized counseling. Approximately 100 new clients and another 150 ongoing clients are served through MQC's case management program each year.

Tobacco prevention education and outreach activities are offered statewide in health care, community-based and school settings to pregnant and parenting adults and teens, girls at risk, family members and caregivers of young children. Outreach efforts also target populations most vulnerable to tobacco addiction, such as women receiving substance abuse treatment, families enrolled in parent education and support programs and teens in alternative school settings.

MQC provides free on site *Ask, Advise, and Refer Brief Intervention* training to maternal-child healthcare providers, hospital staff and physicians, medical and nursing schools, MCH consortia, medical associations, community and social service agencies, statewide. Upon completing the training, MQC provides technical assistance to clinicians and office staff in implementing the *fax to quit* referral process and ongoing cessation support as a routine component of care. In 2010, MQC provided provider training, education and support to approximately 620 maternal and family health care clinicians.

Maternal cigarette smoking has negative effects on all stages of pregnancy, from conception to birth. Women who smoke cigarettes have an increased risk of complications, including spontaneous abortion and premature birth. Previous studies have shown that babies exposed to tobacco in utero are more likely to have a low birth weight and are at increased risk for sudden infant death syndrome. Current research suggests that these babies are also less likely to self-soothe and are more aroused and excitable than newborns whose mothers did not smoke during pregnancy. In spite of the negative consequences of maternal smoking on pregnancy outcome, women continue to smoke.

An MCHS staff member is a participant in the National Partnership to Help Pregnant Smokers Quit. AMCHP holds quarterly Technical Assistance Conference calls for this group.

Statewide there have been many notable accomplishments to reduce smoking. From 2000 to 2007, cigarette taxes were increased from 80 cents per pack to $2.575 per pack (among the highest in the country). Legislation to ban smoking in all workplaces and indoor public places was passed in 2006.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mom's Quit Connection offers 5 A's training throughout the State.		X		X
2. The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke.				X
3.				

b. Current Activities

MQC has collaborated with several maternity hospitals statewide in implementing smoke free campuses. Assisting with staff training and development of new policies, MQC has helped to create a sustainable

systems change and a standardized referral mechanism for patients and visitors needing cessation support.

MQC works to utilize media to promote the NJ Quitline. The multidimensional promotional campaign utilizes education and engagement of health care providers and systems, cable TV, radio and internet advertising, and the creation of a new website to increase awareness and utilization of the NJ Quitline.

The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke. These women are then given referral information for available resources to help them quit. The MCHS staff continues to participate in both the state and national partnerships.

Mom's Quit Connection offers 5 A's training throughout the State. These classes are presented to private practitioners as well as large OB/GYN departments.

The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke. These women are then given referral information for available resources to help them quit. The MCHS staff continues to participate in both the state and national partnerships.

c. Plan for the Coming Year

The PAPP coordinators will continue to strengthen the referral process once a woman is identified at risk for substance use/abuse.

The federal health care reform legislation included provisions to improve access to smoking cessation services for pregnant women. The new legislation prevents states from excluding tobacco cessation drugs from the medications covered by their Medicaid programs and requires Medicaid to cover smoking cessation treatment for pregnant women, including medication and counseling with no cost-sharing requirements. States that voluntarily cover all recommended preventive services and immunizations for all Medicaid enrollees will get an increase in their federal Medicaid reimbursements.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009
Annual Performance Objective	6	5.5	5	4.5	4	3.5
Annual Indicator	5.89	4.54	3.80	4.11	2.91*	4.66
Numerator	33	26	22	24	17*	27
Denominator	559,971	572,337	579,387	583,506	583,511	579,856
Is the Data Provisional or Final?		final	final	final	final	final

Notes - Data source - CDCP - National Center for Injury Prevention and Control http://www.cdc.gov/ncipc/wisqars/ * Rates based on 20 or fewer deaths may be unstable.

a. Last Year's Accomplishments

Suicide is the third leading cause of death among adolescents in New Jersey. Suicide rates are highest among non-Hispanic whites. The death rate from suicide for 15-19 year old males is 6.1 per 100,000. The causes of suicide are complex, and have to do with mental illness, particularly depression and/or adverse circumstances. Suicide attempts among younger people tend to be impulsive and communicative acts, often involving non-lethal means. Nearly one-third of New Jersey suicide victims in 2003 had diagnosed mental illness at the time of the suicide and about one fifth were reported to have symptoms of depression at the time of their suicide. The major mechanisms used in suicides in New Jersey are firearms, suffocation (usually hanging), and poisoning, although mechanisms varies with age.

Firearms and suffocation are the two most lethal means. Females are far more likely than males to use poisoning. Prevention does work. Prevention efforts are increasingly focused on restricting access to lethal means of suicide, especially, but not exclusively, firearms.

New Jersey has taken much action over the past ten years to decrease the risk of completed suicide by children, youth, and young adults. The creation of the State Legislature of the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC) is part of this effort. Elizabeth Dahms, MS, RNC represents the department on this council. The council wrote the NJ State Suicide Prevention State Plan and it was approved to refine and improve the efforts of its many stakeholders to eliminate suicide. As of 2008, New Jersey ranked 47th lowest of the fifty states for completed suicide rates. The NJYSPAC views this as an excellent indication of the hard work and efforts already put into suicide prevention throughout the State. However, the loss of one life and the promise lost of that person's potential is irrecoverable. The pain and grief that is experienced by the survivors of the loss is immeasurable. Therefore, the Council will encourage the State to use this plan to continue and increase the current efforts for suicide prevention.

DHSS supports the Mercer County Traumatic Loss Coalition, which brings together a wide variety of community partners (including schools, local government, police, fire and EMS, and health care providers) to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents.

A clergy conference, "Suicide: A Compassionate Approach to Intervention and Healing" this time for the Jewish clergy on October 29, 2008. Rabbis, Cantors, religious educators, youth leaders and bereavement group facilitators participated in this event held in West Orange, New Jersey.

Through collaboration with the Department of Human Services and the University of Medicine and Dentistry of New Jersey, the following trainings were provided: There were 341 attendees at the 6th Annual Suicide Prevention Conference "We Have Many Children but None to Spare" held on November 18, 2008 in East Hanover, New Jersey and on November 19, 2008 in Somerset, New Jersey.

A free Trauma and Grief in Youth Workshop was held in three locations: January 5, 2009 at University Behavioral Health Care in Piscataway, New Jersey and on January 6, 2009 in Wayne, New Jersey and on January 8, 2009 in Pomona, New Jersey. Over 380 participants were registered.

The Traumatic Loss Coalitions for Youth publishes a newsletter. Over 3,000 individuals are in receipt of this newsletter.

A full day training on Suicide Assessment of Suicide Events and Grief and Trauma in youth on September 24, 2009, approximately 90 participants attended. A full day training entilted “A Compassionate Presence in the Eye of the Storm” was presented by Nicci Spinazzola, LPC on September 30, 2011. A manual from the American Foundation of Suicide Prevention entitled “ After Suicide: A Toolkit for Schools” was distributed.

The Mercer County facilitated memorialization protocols for Mercer County schools. They hosted a full day seminar “Adolescent Anxiety and School Refusal” for 120 participants. Nursing contact hours were awarded.

The New Jersey Suicide Prevention quilt was displayed in the resource room at the 12th Annual Adolescent Health Institute on November 13, 2011. 130 school administrators and nurses and family planning providers attended. Nursing contact hours and professional development certificates were provided.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NJ Youth Suicide Prevention Advisory Council				X
2. Traumatic Loss Coalitions in 21 counties		X		X
3. "Managing Sudden Traumatic Loss in the Schools" - Manual				X
4. Annual Suicide Prevention Conference				X

b. Current Activities

The Mercer Traumatic Loss Coalition (a model funded by DHSS and currently there is one in every NJ county) holds monthly Traumatic Loss Meetings. Participants include local school counselors, administration, law enforcement, clergy, and mental health organization staff. Recently the discussion revolved around a local High School regarding recent loss of students. The New Jersey Suicide Prevention Quilt is displayed and suicide prevention information is distributed in the resource room at the Annual Adolescent Health Institute, this year it is scheduled for in November 2012. The Traumatic Loss Newsletter is distributed twice a year.

The Mercer TLC co-sponsored the 8th Annual Youth Suicide Prevention Conference, Preventing and Responding to Adolescent Suicide Focusing On Contagion on December 1, 2010 for 350 participants. A Garrett Smith grant application was submitted in February 2011, it included the New Jersey State Suicide Plan.

c. Plan for the Coming Year

DHSS continues to work with a wide variety of community partners, such as the Mercer County Traumatic Loss Coalition, to develop plans to prevent and address suicide and other sudden traumatic deaths and losses among children adolescents and families.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective		78	79	80	85	85	
Annual Indicator	80.5	77.6	76.7	82.6	85.6	84.2	
Numerator	1,398	1,379	1,315	1,446	1,358	1,359	
Denominator	1,737	1,776	1,714	1,751	1,587	1,613	
Is the Data Provisional or Final?				Final	Final	Provisional	

Notes - Facilities for high risk deliveries defined as Intensive and Regional Perinatal Centers.
2010 data from provisional EBC file.

a. Last Year's Accomplishments

Very low birthweight (LBW) is an important risk factor for future health conditions, disability, and death. Factors that have contributed to this increase are: the increases in multiple births, which are more likely to result in VLBW infants than singleton births (though singleton LBW has also increased); obstetric interventions such as induction of labor and cesarean delivery; infertility therapies; and delayed childbearing.

Despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early entry to prenatal care and comprehensive services, NJ has not experienced improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status

Indicators. The increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing.

The percent of VLBW infants delivered at facilities for high-risk deliveries and neonates has increased through continuous quality improvement activities, which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC). The Reproductive and Perinatal Health Services (RPHS) coordinates regional continuous quality improvement activities within each of the regional MCHCs. Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through fetal-infant mortality review and maternal mortality review systems, as well as analyzing data collected through the electronic birth certificate (EBC). Currently, all hospitals providing maternity services report births through the EBC. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

As a follow-up to the Perinatal and Pediatric Bed Need Task Force, a statewide collaborative partnership to gather and analyze data related to quality of care for newborn infants and their families was convened. Most of the Regional Perinatal Centers (RPCs) are members of the Vermont Oxford Network (VON) and believe that the prenatal and postnatal data available through this network could improve the system of total quality improvement on a regional and statewide level.

The Directors of Neonatalogy of the RPCs have been meeting to develop the NJ NICU Collaborative. All 15 RPCs have submitted the documents necessary to participate in the NJ Neonatal Collaborative to establish a statewide reporting program based on the hospital-level NICU performance data submitted to the Vermont Oxford Network, Inc.

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Consortia TQI Activities				X
2. Perinatal Designation Level regulations				X
3. MCH Task Force on Hospital-based perinatal and pediatric services				X
4. Development of the NJ VON Collaborative				X

b. Current Activities

The regional quality improvement activities within each of the 6 MCHCs coordinated by RPHS include the regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the EBC.

The Directors of Neonatology of the RPCs have initiated a NJ VON Collaborative to ensure: the development of a voluntary, collaborative network of neonatal providers, to support a system for bench marking and continuous quality improvement activities for perinatal care; the opportunity to develop a responsive, real time, risk-adjusted, statewide perinatal data system; and the ability to integrate existing state and front-end perinatal data systems.

All of the regional perinatal centers (RPC) in the State currently participate in the NJ NICU Collaborative. The initial education effort centered on hand hygiene. The NICU Collaborative achieved active infection reduction activity at all centers.

The NJ NICU collaborative has joined the State Collaborative Group, a sub unit of the Vermont Oxford Network (VON).

The Chair of the NJ NICU Collaborative provided a progress report on the infection indicator at the annual March of Dimes NJ Chapter, professional conference. Over 100 health care professionals attended this event.

c. Plan for the Coming Year

The NJ NICU Collaborative plans to continue to address infections as the common indicator in all of the RPC's. Site visits to include best practices will be conducted regionally. The collaborative has planned six meetings for the year, with three being conducted via the web. Education will be an ongoing goal of the collaborative.

The NJ NICU Collaborative is participating with 7 other states in the NCABSI (catherter-associated bloodstream infection) collaborative, a multistate initiative to eliminate central-line associated blood stream infections in the NICU The NCABSI project is part of the overall AHRQ-funded On the Cusp: Stop BSI national initiative.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Annual Objective and Performance Data	2005	2006	2007	2008	2009	2010
Annual Performance Objective	79	79	79	79	79	79
Annual Indicator	77.9	77.1	76.6	79.4	79.5	81.3
Numerator	86,278	86,158	86,363	85,891	85,018	84,198
Denominator	110,697	111,727	112,715	109,539	106,944	103,586
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Provisional

Notes - Provisional 2010 data from provisional EBC file.
See Chart 2 - 1st Trimester PNC attached to Section IV. A. Background and Overview.

a. Last Year's Accomplishments

In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in NJ. The Task Force was comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force presented a report and recommendations to Commissioner Howard in July 2008. Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications was developed to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report. This competitive request for applications sought to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. It is anticipated that projects seeking funding should be able to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and or increasing access for reproductive age women and their partner for preconception and interconception care. Nine projects were funded within the Access to Prenatal Care Initiative representing a variety of best practice models.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers Healthy Babies coalition activities				X
2. MCH Consortia outreach and education activities				X
3. Commissioner's Prenatal Care Task Force				X
4. Access to Prenatal Care Initiative				X

b. Current Activities

Based on recommendations from the Prenatal Care Task Force, Infant mortality reduction funding was redirected from Healthy Mothers, Healthy Babies (HM,HB) Coalition outreach and education to the Access to Prenatal Care Initiative request for applications. Activities from the 8 HM,HB Coalition including outreach to identify women in need of prenatal or postpartum care and case management, were phased out during the end of 2009.

c. Plan for the Coming Year

Following recommendations from the Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities are described as follows:

Central NJ MCHC will implement a Preconception, Interconception and Prenatal Education awareness campaign targeting women of childbearing age, youth and men in the target area, and will provide a patient navigator to serve at-risk pregnant and/or interconception women within the service region.

Hudson Perinatal Consortium will provide outreach and education, coordination of health benefits including insurance coverage, a medical home, and WIC services for program participants who are entering prenatal care. Hudson Perinatal Consortium will coordinate doula training and childbirth education sessions.

Children's Home Society will target outreach to the Latino and African American community with emphasis on adolescents. Children's Home Society will provide access to prenatal care, interconception and preconception care and outreach and education services in the target area.

Southern Jersey Family Medical Center will provide an integrated service delivery model for reproductive healthcare; partnering with Planned Parenthood of Southern NJ and the Southern NJ Perinatal Cooperative.

Southern NJ Perinatal Cooperative will establish a regional practice collaborative to foster a comprehensive approach to community awareness, provider training, service integration and improved access to prenatal care, interconception and preconception care.

Northern NJ MCHC will provide a patient navigator model of care with expansion of the Paterson Healthy Mothers Healthy Babies Coalition model.

Gateway Northwest MCH Network will provide a technology based prenatal education/outreach model for pregnant/postpartum clients with special emphasis on adolescents through use of text messaging and email.

Regional Perinatal Consortium of Monmouth and Ocean Counties will provide and coordinate subgrants for direct care including Centering Pregnancy and intensive case management services.

Newark Community Health Center will provide a Centering Pregnancy model with special emphasis on pregnant women with HIV/AIDS.

The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. The projects utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doulas will be in the third year of a three year grant project period. Beginning with the SFY2013, the Department is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence. Funding would come from reduction of infrastructure costs due to the MCHC mergers and reductions to grantees with extended vacancies of grant funded positions. In addition, the MIEC Home visiting projects complement the services provided in the Access to Prenatal Care initiative.

D. State Performance Measures

State Performance Measure 1: *The percentage of Black non-Hispanic preterm infants in NJ*

Annual Objective and Performance Data	2004	2005	2006	2007	2008	2009	2010	2011
Annual Performance Objective			12	11.5	11.5	11	11	11
Annual Indicator	11.6	11.5	12.1	11.3	11.0	10.6	10.0	
Numerator	1,912	1,866	2,039	1,945	1861	1744	1573	
Denominator	16,447	16,221	16,864	17,256	16,858	16,507	15,725	
Is the Data Provisional or Final?					Final	Final	Provisional	

Notes - Source of provisional 2009 data is the Electronic Birth Certificate file which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.
See Chart 5 Low Birthweight by Race/Ethnicity attached to Section IV. A. Background and Overview.

a. Last Year's Accomplishments

Maternal and Child Health Services chose the percent of black preterm births in New Jersey as State Performance Measure #1. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in New Jersey. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative is to increase the rate of first trimester prenatal care in New Jersey to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

The Department's commitment to reduce black infant mortality has been demonstrated in previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's Prenatal Care Task Force and the Access to Prenatal Care Initiative.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers /Healthy Babies Coalitions			X	X
2. Healthy Start		X		X
3. Preconceptual health counseling/training				X
4. Black Infant Mortality Reduction				X
5. MCH Consortia outreach and education activities			X	X
6. Commissioner's Prenatal Care Task Force				X
7. Access to Prenatal Care Initiative				X

b. Current Activities

Reproductive and Perinatal Services has implemented program evaluation of all funded BIMR activities.

c. Plan for the Coming Year

Following recommendations from the Commissioner Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality

access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities have been previously described in the National Performance Measure #18 section.

The eight Access to Prenatal Care Initiative agencies provide access to prenatal care services as a means to decrease infant mortality rates. Projects are located in the highest need areas of 13 of the 21 counties. All of the projects address health disparities as seen in the local communities. The projects utilize evidence-based models including Patient Navigators, Centering Pregnancy and Doulas will be in the third year of a three year grant project period. Beginning with the SFY2013, the Department is restructuring Access to Prenatal Care Grants to include preconception/interconception counseling incorporating the Life course model into the projects. This component would emphasize the health of reproductive age women including linkages with healthy lifestyles and medical home. All projects will promote cultural competence. Funding would come from reduction of infrastructure costs due to the MCHC mergers and reductions to grantees with extended vacancies of grant funded positions. In addition, the MIEC Home visiting projects complement the services provided in the Access to Prenatal Care initiative,

The Department is a partner with the March of Dimes NJ Chapter in the Healthy Babies are Worth the Wait a program to reduce preterm births among African American women in Newark.

State Performance Measure 2: *The number of Regional MCH Consortia conducting community-based Fetal and Infant Mortality Review (FIMR) Teams and implementing recommendations through a Community Action Team.*

Annual Objective and Performance Data	2006	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0	100.0
Numerator	6	6	6	6	6	6
Denominator	6	6	6	6	6	6
Is the Data Provisional or Final?		Final	Final	Final	Final	Final

Notes - Source: Maternal Child & Community Health Service Unit

a. Last Year's Accomplishments

State Performance Measure #2 was selected to monitor progress toward the implementation of recommendations from community-based Fetal and Infant Mortality Review Teams (FIMR) through Community Action Teams (CATs). This infrastructure building service will impact on National Performance Measures #15, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

On a local level, the MCH Consortia have used FIMR as a component of their quality improvement program both for need assessment and program development. Findings are shared with member hospitals for use in quality assurance activities. Policy has been implemented, such as the promulgation of fetal autopsy guidelines and consumer and professional education initiatives have addressed findings such as inadequate knowledge of fetal kick count and premature labor, and bereavement support issues.

Until the implementation of the NJ FIMR, there has not been a statewide approach to FIMR. Therefore, FIMR findings have not played a major role in need assessment and quality improvement at the state level. NJDHSS and the MCH Consortia are now working collaboratively to use the information obtained

from NJ FIMR for policy development and continuous quality improvement activities on the state and local level. In addition to issuing a Statewide Annual NJ FIMR report, common areas of concern identified from the local reviews will be addressed as a collaborative effort by all local projects through statewide initiatives. Each MCH Consortia has a Community Action Team (CAT) which consists of a diverse group of community leaders. The CAT reviews recommendations from the Case Review Team, prioritizes identified issues and designs and implements intervention in a variety of ways.

Related to FIMR is New Jersey's system of Maternal Mortality Review (MMR), which was established, in the late 1970s and revised in 1999. The revised New Jersey Maternal Mortality Review is based on the National Fetal-Infant review process, using a multidisciplinary model, data abstraction, de-identified case summary, and Community Action Teams to implement programs to effect change. The FHS/Reproductive Health and Perinatal Services coordinates the New Jersey MMR process.

All pregnancy-associated deaths occurring in 1999 through 2005 have been reviewed. The Case Review Team, which also serves as the Community Action Team, has reviewed the findings and made recommendations. A report of the findings and recommendations for the years 1999-2005 is expected in the summer of 2010.

A birth certificate, death certificate and hospital discharge data matching strategy is used to improve identification of maternal deaths using the CDC expanded definition of a pregnancy-associated death. Once cases are identified, Reproductive and Perinatal Health Services verifies the cases by reviewing the death certificate, autopsy report, Report of the Investigation of the Medical Examiner, law enforcement records, or by contacting the hospital or health care provider directly. Cases deemed pregnancy-associated deaths are entered into a log. A copy of the log and death certificates is forwarded to the Central New Jersey Maternal and Child Health Consortium for data abstraction. The CNJMCHC coordinates data abstraction through a grant from DHSS. Data abstractors are nurses with extensive maternal and child health backgrounds, trained in medical data abstraction, and case summary development.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing NFIMR in six MCHC Regions.				X
2. Implementation of FIMR process uniformly across all projects.				X
3. Reporting of data and local findings to NJDHSS for inclusion in statewide database.				X

b. Current Activities

The number of FIMR projects statewide continues to be 9, of which 7 are funded with MCH Block Grant monies through the 6 regional MCH Consortia. In order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective, the process is implemented uniformly across all projects. All local projects of NJ FIMR follow the National FIMR guidelines for community FIMR with modifications as needed for NJ. The data collection process includes both chart abstraction and a maternal interview. A multidisciplinary case review team reviews the information and based on findings, makes recommendations to a Community Action Team. Data and findings from FIMR projects are submitted to the NJDHSS for inclusion in a statewide database.

Obtaining the maternal interview continues to be an impediment to the process. The success in obtaining maternal interviews has improved through the use of nurses through contracting with a local health department or VNA. However, obtaining a maternal interview continues to be a challenge.

c. Plan for the Coming Year

All local projects of NJ FIMR will follow the National FIMR guidelines for community FIMR in order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective. Data and findings from local FIMR projects will continue to be submitted to the NJDHSS for inclusion in the

statewide database. The Reproductive and Perinatal Health Services will continue to coordinate the NJ Maternal Mortality Review process modeled after the National FIMR process.

State Performance Measure 3: *The percentage of children with elevated blood lead levels (≥20 ug/dL).*

Annual Objective and Performance Data	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Annual Performance Objective	0.3	0.2	0.2	0.2	0.1	0.1
Annual Indicator	0.3	0.2	0.1	0.1	0.1	0.1
Numerator*	450	350	261	231	251252	229
Denominator*	179,158	161,776	175,053	175,732	180,756 185,055	180,681
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Provisional

*Children ≤ 6<17 years of age
Notes - Source: Childhood Lead Poisoning Prevention Program Database, MCCH, FHS.

a. Last Year's Accomplishments

Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead poisoning. The percentage of children with elevated blood lead levels (State Performance Measure # 3) was chosen because children in New Jersey have a higher than average exposure to lead in their environment and a higher percentage of elevated blood lead levels than the national average. In CY 0908,2011 0.78% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During CY 102011, more than 230,000 blood lead tests were reported on 216,918217,110 children. Of the children tested during CY 102011, 83.32% were under the age of 6 years. Among these children, 0.6% had results > 10 ug/dldL and 0.1% had results > 20 ug/dldL. Of all the children tested, 102,836101,497 were between six months and 29 months of age, the ages at which state rules require all children to be screened for lead poisoning. This is 46.145.5% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 75% of children have had at least one blood lead test by the age of two years, and 54% of children have had at least one blood lead test by the age of 1 year.

The web-based data and surveillance system, LeadTrax, containing medical and environmental case management modules continued to be customized, and remained CDC data requirements compliant. The expansion of the LeadTrax local health department users base continued to be a priority, providing hands-on training and access for the intended users of the remaining local health departments in the State.

In August 2011, the NJ DHSS published the FY 2010 Annual Report on Childhood Lead Poisoning in New Jersey for dissemination of this data to local health departments and the public.

During CY 2011, because of ongoing efforts, the percentage of electronic reporting increased to 99% from the CY 2010 rate of 98%. DHSS is in the process of assisting remaining laboratories to make the transition from hard copy to electronic reporting. Through LeadTrax, more laboratories will be able to report electronically because of the system's capability to accept HL7 and Microsoft Excel reporting templates, which were developed exclusively for screening sites that use LeadCare analyzers.

Collaborative efforts with Medicaid and its contracted managed care providers continue in order to monitor and increase the number of Medicaid-enrolled children screened for lead poisoning.

A conference, held on April 16, 2010, was sponsored by the Interagency Task Force on the Prevention of Lead Poisoning as a means to highlight the State's accomplishments and new collaborations and initiatives that address lead poisoning prevention. The conference's three tracks (health, housing, and the environment) provided timely information for the 300 registered attendees. DHSS provided technical assistance to the thirteen Lead-Safe Model Cities to assist them in the implementation of their signed agreements with the Department of the Public Advocate.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Surveillance system enhancements and universal electronic reporting.			X	X
2. Newark Partnership for Lead Safe Children.			X	X
3. Regional Childhood Lead Poisoning Prevention Coalitions.			X	X
4. Plan for Elimination of Childhood Lead Poisoning Prevention Coalitions in NJ.			X	X
5. Nurse case management and environmental investigation protocol enhancements for highest risk jurisdictions (>=10 ug/dl).			X	X
6. Targeted screening enhancements (children exposed to parental occupational exposure, refugee children to age 16 years).			X	X

b. Current Activities

The expansion of the LeadTrax local health department users base continues to be a priority with an expected completion date of December 2012. However, this process is expected to continue beyond that due to staffing changes, requiring new staff to be trained and given access to LeadTrax as they are hired or reassigned to CLPP. LeadTrax was customized to meet CDC data requirements and data collection requirements due to changes in state regulations.

DHSS continues to place a greater focus on implementing primary prevention initiatives and strengthening strategic partnerships at all levels. Efforts focus on identifying and addressing lead hazards prior to young children moving into units or homes, as well as identifying lead-safe housing for families in need of emergency relocation due to a lead poisoned child. Monitoring of the Elimination Plan continues to be coordinated by DHSS to assure that the state is collectively making progress to eliminate childhood lead poisoning.

In the highest risk city, Newark, the CLPP Program, located within the Newark Department of Child and Family Well-Being, continues to administer the Newark Partnership for Lead Safe Children. The Partnership's focus is on empowering health, social services, and housing organizations to build local capacity to address the lead problem in New Jersey's largest city.

All children in target areas with elevated blood lead levels that required public health intervention are provided services through a CLPP Program as described earlier. Children in other areas of the State with elevated blood lead levels also continue to receive services provided by their local health department as required by N.J.A.C. 8:51.

c. Plan for the Coming Year

DHSS will fully incorporate a healthy homes approach into its services provided by local health departments that provide case management and environmental intervention services for children with elevated blood lead levels. Training on healthy homes principles and procedural protocols for staff of local health departments and home visitation-based programs in the Department of Children and Families (DCF) will continue. DCF's home visitation programs, funded in part by NJ's MIEC Home Visiting Formula Grant, provide services to pregnant women, infants, and young children in addition to assessing the

suitability of homes for placement of children who have entered foster care or are registered as family child care homes. Emphasis will be on developing strategic partnerships with additional home visitation agencies that serve highest-risk, hard to reach populations as identified in the HH/LPP work plan and with communities involved in environmental justice issues including but not limited to exposure to sources of lead.

DHSS was notified in August 2011 of its awarding of a 3-year grant from the Centers for Disease Control and Prevention (CDC) for the support of a Healthy Homes and Lead Poisoning Prevention (HH/LPP) program. A condition of the award is to establish a HH/LPP Advisory Committee and subsequently develop a Strategic Plan during the first project year that commenced on September 1. This initiative's focus is on training of health, human services, and housing home visitation staffs, establishment of an assessment tool with related resource and referral processes, enhanced data collection into a singular database built upon LeadTrax, and emphasis on compliance and enforcement of protective policies and laws.

State Performance Measure 4: *Reduce the proportion of children and adolescents who are overweight or obese.*

Annual Objective and Performance Data	2001	2005	2007	2009	2010	2011
Annual Performance Objective						
Annual Indicator	24.7	26.8	26.6	24.5		
Numerator						

Notes – The percentage of New Jersey high school students who have a BMI that would classify them as overweight (BMI>85%), NJ Student Health Survey 2009

a. Last Year's Accomplishments

Three CSH regional grantees (one each located in a northern, central and southern region of the state) and 1 local grantee project in Newark and Montclair in Essex County and 28 school partners, including schools with disparate student populations began to implement CDC's Coordinated School Health (CSH) model during the 2010-2011 school year. Activities included: identifying a School Health Coordinator at each school; creating a school health team of diverse composition; analyzing the strengths and weaknesses of existing school health policies, curricula, programs and services using CDC's self assessment tool: the School Health Index (SHI); and, developing an action plan that prioritizes areas for improvement. Grantees assured that all school partners purchased and piloted the use of Fitnessgram software; conducted one youth focus group and one school health awareness/educational event; created a Youth Advisory Council.

The CDC-funded CSH staff provided professional development (PD) and technical assistance for the DHSS grantees and included: Fitnessgram, School Health Index, HECAT and PECAT, Food Service Directors' Workshop, Hands on Health (NJ AHPERD) and Fitnessgram Train the Trainer. During 2010 - 2011, CDC funded CSH staff convened student Focus Groups with schools and shared guidance with DHSS grantees. Collaboration continued monthly as CDC CSH staff participated in conference calls and meetings, offering CDC resources and updates on upcoming PD events. DOE, through a cooperative agreement with CDC, conducted the 2011 Student Health Survey.

The ShapingNJ Partnership included over 100 health, education, parks and recreation, agriculture and business organizations. In 2011, the CDC NPAO cooperative agreement directed the state to concentrate its efforts on five settings: schools, communities, child care centers, worksites and health care facilities.

ShapingNJ accomplishments included: 1) CDC approval of the NJ NPAO State Plan for obesity prevention and supplemental funding for ***ShapingNJ*** strategies in the areas of child care, baby friendly hospitals and community health; 2) creation of a farmer's market at Beth Israel Hospital Farmer's Market, Newark;3) Conducting community focus groups to ensure that intervention strategies would resonate with

the target populations; 4) development of ***ShapingNJ*** Partnership Objectives: a) increase the number, reach, and quality of policies and standards set in place to support healthful eating and physical activity in various settings; b) increase access to and use of environments to support healthful eating and physical activity in various settings; c) increase the number, reach, and quality of social and behavioral approaches that complement policy and environmental strategies to promote healthful eating and physical activity.

Effective January 2011, state law required food chains with 20 or more locations nationally to provide calorie counts for food and beverages. New Jersey was also one of 19 states that have stricter nutritional standards for school lunches, breakfasts and snacks than mandated by federal U.S. Department of Agriculture requirements.

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
NJ NPAO State Plan developed				X
CDC's CSH model implemented by DOE (2008 CDC cooperative agreement and DHSS, Adolescent Health (2010).				X
ShapingNJ Partnership identifies 2 venues- child care centers and schools- directly relevant to children and adolescents for implementation of E-B strategies				X
Secured funding to implement strategies in child care, baby-friendly hospitals and healthy communities				X
Farmers market established in a high risk area (Newark).				X
Community focus groups were held				X
Annual regional Sustainability meetings with State, grantees & schools				X
Bi-/tri-annual State-wide sustainability workgroup meetings				X

b. Current Activities

A collaborated effort for CSH implementation between DOE and DHSS is underway as coordination of meetings and sharing of resources becomes more established. For the current school year (2011-12), the DHSS CSH grantees are implementing the School Health Action Plans (SHAPs) developed by the 28 school partners at the end of the 2010-2011 school year. Schools focusing on NPAO prevention strategies will be identified and changes in school health and wellness policies monitored. There is a state-level CSH sustainability workgroup that has met twice: January and February 2012. Each regional grantee is coordinating sustainability meetings with school administrators and school health coordinators. The southern region held a meeting on March 1, 2012. The northern region is scheduled for May 14th and the central region on May 24th. Each region is coordinating a youth leadership development training. A State-wide school garden directory is under development and is expected to be posted on the FHS web-site by the start of the school year September 2012.

The DHSS CDC CSH liaison is actively involved with ***ShapingNJ*** school strategies. The liaison convened a webinar addressing the "How To" of School Wellness Council development. CDC CSH continued to offer professional development opportunities including a Leadership Academy, two regional Food Service Panel Workshops, NASPE Pipeline training, two regional physical education best practices workshops (April 2012), and a Grant Writing workshop (May 2012). DOE, through a cooperative agreement with CDC, is finalizing the results of the 2011 Student Health Survey for publication.

Nutrition, physical activity and obesity prevention (NPAO) in children and adolescents are being addressed through the school setting identified in the CDC NPAO State Plan. ***ShapingNJ*** is: 1) focusing on policy and environmental change strategies; 2) targeting resources to those at greatest risk for obesity and other chronic diseases; 3) promoting and utilizing evidence-based strategies among all partners; and, 4) establishing priority populations and strategies, identifying available data sources and gaps, and setting measurable program objectives. MCHS, Child and Adolescent Health Program and Rutgers

University are taking the lead for the implementation of the NPAO strategies and activities targeting schools.

ONF supports three HealthCorps projects in Central High School, Newark, North Bergen High School and Cliffside Park High School with MCH BG funds. These projects recruit and hire a school-based youth coordinator to address nutrition, physical activity and healthy lifestyle. Additional ONF, ***ShapingNJ*** activities include: 1) Leveraging funds to secure additional healthy community pilots. In addition to CPPW-STI funds in the community pilots, ONF partnered with the RWJ F, Partners for Health, and the Office of Minority and Multicultural Health (OMMH) and is funding 5 additional communities and 6 CBOs to implement one of the ***ShapingNJ*** community strategies. ONF funded $15,000 each to 3 of 8 Healthy Community grants from January 1 – December 31, 2011; 2) building skills and capacity of partners through the ***ShapingNJ*** Training Institute; 3) evaluating the ***ShapingNJ*** partnership using the Wilder assessment tool; 4) revising the Child Care Regulations; 5) conducting statewide trainings for food service staff and child care providers; 6) developing materials for school model nutrition policies and physical activity programs; and 7) implementing the Surveillance Plan .

The New Jersey Department of Transportation's (NJDOT) Safe Routes to School, a program that encourages bicycling and walking and Complete Streets, which promotes walking and biking policies, in collaboration with local jurisdictions, for health and fitness.

c. Plan for the Coming Year

CSH grantees will be expected to promote the Healthier US Schools Recognition sponsored by the USDA or the Alliance for a Healthier Generation (AHG) recognition. Year 3 grant requirements will include: 1) school outreach for LHD involvement; meet and greet between County Education Specialists and County SHS; Coordinate the School Health Team and School Climate Team; introduction of DCF County CIACC and point person at school w/ SHC 2) Youth advocacy/policy training; the SH Wellness Team = "Youth/Adult Partnership"; 3) School match of $1,500 to fund the SHC stipend; 4) Next steps for Fitnessgram implementation; 5) Regional grantees collaborating to create/maintain Facebook/other social media page; 6) Grantees and schools to register to receive ShapingNJ e-newsletter; 7) Schools to identify and monitor one academic indicator in need of improvement.

The CDC funded DOE staff will provide professional development opportunities including: to MCSH CDC CSH. The "Healthy Schools Communities "event planned for October will support community partnering, highlighting physical activity for families and students. This workshop supports sustainability through community involvement. The CSH sustainability action plan will be implemented with key strategies in place for CDC CSH schools. When the CDC cooperative agreement ends February 28, 2013, funding availability for a competitive application is uncertain. However, States are being strongly encouraged to partner with their State Chronic Disease Program to use schools as a venue for the implementation of prevention strategies.

State Performance Measure 5: Percentage of newborns who are discharged from NJ hospitals, reside in New Jersey, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented.

Annual Objective and Performance Data	2008	2009	2010	2011	2012	2013	2014
Annual Performance Objective	NA	75%	77%	79%	81%	83%	85%
Annual Indicator	74.4%	79.0%	86.05%	78.1%*			
Numerator	2250	2356	2425	2115			
Denominator	3023	2981	2818	2707			

*Note – Data from 2011 is incomplete, follow-up reports are still being received for these children..

a. Last Year's Accomplishments

Provisional data indicates that for 2011, 78.9% of infants received follow-up after referring on inpatient screening. This statistic continues to rise slowly, it was 70% in 2007, and is an area EDHI is working on improving.

The Early Hearing Detection and Intervention (EHDI) reporting module in the NJ Immunization Information System (NJIIS) is utilized by audiologists and other practitioners, who are conducting hearing follow-up, to report outpatient exams. NJ-EHDI receives approximately 86% of reports through this Web-based application and thirty-two new users were trained during 2011.

The EHDI Program continued a project begun in October 2009, where HRSA funding allows case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up, the level of effort put into this by each hospital and the success of their efforts varies widely. This program provides supplemental contacts to compliment the hospital's outreach efforts. During 2011, the case managers contacted 1,117 families, contributing significantly to the improvement in follow-up rates.

In April 2011, the NJ Pediatric Hearing Health Care Directory was updated and improved as a searchable on-line directory with the ability to map facility locations and obtain driving directions. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services.

The EHDI program collaborated with staff from the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS) granting NJIIS-EHDI module access to DCF staff nurses who are responsible for health care for children in foster care placement. In April 2011, 235 DYFS staff members attended one of 4 webinars that provided information about the EHDI module and new hires watch a recorded version of the webinar. This effort will help to ensure children in foster care receive appropriate hearing follow-up services since this population has been much more likely to be lost to follow-up.
Two additional FQHC purchased equipment to conduct re-screening to supplement the three centers that began this service in 2010. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up.

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational outreach to practitioners (audiologists, pediatricians, otolaryngologists, etc.).				X
2. Hospital level surveillance reports.			X	
3. Increase in follow up and reporting for those who are not screened while inpatient or refer on initial screening.	X	X		

b. Current Activities

To begin using telepractice to benefit children with hearing loss, the EHDI program funded one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to hire two part time consultants. They will use laptops with web-cameras to participate in initial early intervention family meetings via remote access. The consultants are currently developing resource materials and developing the referral process.

The program is planning a webinar for SCHS case managers, EI staff, audiologists and physicians on the impact of unilateral hearing loss. These children are less likely to be enrolled in EI services, possibly due to an erroneous assumption by providers that these children are not eligible for services or would not benefit from services.

Another webinar under development is an EHDI overview for hospital staff responsible for newborn hearing screening. Due to the frequent changes in staff in some hospitals, a recorded webinar will be

available to explain the EHDI program's regulatory obligations to ensure and improve hospital compliance.

The EHDI program recently is working with staff from the Communicable Disease Service division to notify the EHDI program of children diagnosed with meningitis. The goal of this collaboration is to ensure that children with hearing loss caused by meningitis receive timely referral for audiology and otolaryngology services, since a delay in can impair the ability for the child to benefit from cochlear implantation.

c. Plan for the Coming Year

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent semi-annually, and in intervening quarters, hospital contacts receive a list of children that are still in need of follow-up after missed or referred inpatient hearing screening. New audiology facility reports will be created and routinely distributed to let facilities know how well they are doing with timeliness of outpatient follow-up and referral into Early Intervention services.

The EHDI program will begin sending follow-up letters to the primary care provider of infants that are in need of additional follow-up to prompt these providers to refer families for audiologic evaluation. EHDI staff will provide educational presentations to pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses Webinars, to make educational outreach efforts more accessible to the target audiences, to decrease staff travel time, and to improve efficiency while decreasing costs.

The parent support services provided through the REIC will continue to develop and expand through the coming year. As contacts with families are implemented the program will adjust the resources and scripts used for the contact and identify weaknesses in the EHDI process that are identified through individual conversations with families.

The program will participate in a National Initiative for Children's Healthcare Quality Learning Collaborative to identify small tests of change to improve hearing screening and follow-up.

The EHDI program will be reviewing the interoperability of the EHDI information system and looking for opportunities to utilize Electronic Health Record data to decrease the need for duplicate data entry. As the Bureau of Vital Statistics and Registration begins to implement a new Electronic Birth Registration System, the EHDI program will work with the program to ensure the continued capture of inpatient hearing screening results and risk indicators through this system.

State Performance Measure 6: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to New Jersey's Special Child Health Services Case Management Unit who are receiving services.

Annual Objective and Performance Data	2009	2010	2011	2012	2013	2014
Annual Performance Objective	NA	NA	70%	75%	80%	85%
Annual Indicator						
Numerator						
Denominator						

Note: At present data is not available. We are implementing a new system to track children reported to the BDARS to the services they receive. This system was rolled out starting with one case management unit in August 2011. All units now have access and are back-entering data.

This new State Performance Measure was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning and research, to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based registry of children with all defects. Starting in 2003, the Early Identification and Monitoring (EIM) Program received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses, was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects up to age 6, and added severe hyperbilirubinemia as a reportable condition. The system refers all living children and their families to our SCHS Case Management Units. The newly implemented case management module will monitor the progression into the service stream.

New Jersey has been very successful in linking children registered with the Birth Defects Registry (also known as the Special Child Health Services Registry) with services offered through our county based Special Child Health Services Case Management Units. However, the system did not track children and families to determine if and what services were offered to any of the registered children. To address this weakness, a second module was added to the Birth Defects and Autism Reporting System (BDARS) and was fully implemented in January 2012. This module will be used by the Special Child Health Case Management Units (CMU) to track and monitor services provided to the children and their families. It will electronically notify a CMU when a child living within their jurisdiction has been registered. Also included in the module is the ability to create and modify an Individual Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

The case management module of the BDARS will allow CMUs to receive registrations in real time and will allow for faster family contact and in assisting a registered child in gaining access to appropriate health and education services.

We have chosen to add this performance measure to show our commitment to continually improving access to services for families having children with special health care needs.

a. Last Year's Accomplishments

In 2011, CDC continued to fund the BDARS through a cooperative agreement for improvements in the Birth Defects Surveillance. Rutgers, the State University -- Bloustein Center for Survey Research continued the deployment of the new Case Management Module for the Birth Defects & Autism Reporting System (BDARS). The Bloustein Center for Survey Research (BCSR) at Rutgers continued to work with EIM Program staff and staff from the SCHS county-based Case Management Units to finalize the development of the case tracking and management component of the BDARS. The SCHS Case Management Module of the BDARS was rolled out starting in August 2011. Staff from each case management unit were trained during the roll out period. Implementation of this component began in August 2011 at one Case Management Unit. As each unit went on-line, notification of a newly registered child living within their jurisdiction switched to the electronic system, replacing the need to mail paper copies of the registration. The full rollout of the case management component continued over the next several months, with all CMUs utilizing the new system by January 2012. As of the end of 2011, most case management units were able to access and manage new cases through the BDARS.

BDR staff continued to provide training to birthing facilities, autism centers, and Case Management Units in the use of the electronic BDARS. They also continued to assist the units as they transition from the paper-based system to the electronic system. Staff continued to monitor the implementation of the electronic BDARS and will assist reporting agencies with concerns.

In 2011, the SCHS Registry:
• Processed approximately 9,800 registrations,
• Identified 9,540 new children with birth defects and other special health needs,
• Referred nearly 9,180 families to the SCHS County-based Case Management Units, and
• Received nearly 2,200 new autism-related registrations

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Annual Audits				X
2. Case Management level service reports.			X	
3. Increase in # of families being offered services.	X	X		

b. Current Activities

BDARS staff continue to collaborate with staff from the Family Centered Care Program (FCCP) and BCSR to implement the case management module for the electronic BDARS. Registry staff held meetings with FCCP staff and BCSR to determine the content for the case management module and to assure the final product met specifications.

In 2012, CDC will continue to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance. Rutgers, the State University -- Bloustein Center for Survey Research will continue the making improvements to the Case Management Module for the Birth Defects & Autism Reporting System (BDARS). The major enhancement will be the addition of a Pulse Oximetry Screening module which will be used for the reporting of all infants who fail their mandated pulse oximetry screen. Registry staff will follow-up with hospital staff to determine the status of each child who failed their screen.

Site visits will be conducted in each of New Jersey's birthing hospitals and County Case Management Units to ensure proper usage of the new BDARS. Also BDARS and FCCS staff will be reviewing the CMUs performance in linking referred families to services. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDARS and FCCS.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics. BDR staff will continue to work with the agencies to ensure complete and appropriate referral to services, especially during the transition from paper forms to electronic registration.

c. Plan for the Coming Year

In 2013, CDC will continue to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance. Rutgers, the State University -- Bloustein Center for Survey Research will continue the making improvements to the Birth Defects & Autism Reporting System (BDARS).
BDR staff will continue to provide training, on an as-needed basis, to birthing facilities, autism centers, and Case Management Units in the use of the electronic BDARS. They will also continue to provide assistance to these entities as they transition from the paper-based system to the electronic system. Staff will continue to monitor the implementation of the electronic BDARS and will assist reporting agencies with concerns. Modifications and improvements will be added to the BDARS to ensure it fully meets the needs of both the SCHS Registry and Case Management staff.

Site visits will be conducted in each of New Jersey's birthing hospitals and County Case Management Units to ensure proper usage of the new BDARS. Also BDARS and FCCS staff will be reviewing the CMUs performance in linking referred families to services. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDARS and FCCS.

BDARS staff will continue to work with the agencies to ensure complete and appropriate referral to services, especially during the transition from paper forms to electronic registration.

State Performance Measure 7: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

Annual Objective and Performance Data	2009	2010	2011	2012	2013	2014
Annual Performance Objective	NA	NA	4.25yrs	4yrs	3.5yrs	3yrs
Annual Indicator	4.4 years	4.2	4.5			
Numerator						
Denominator						

Notes - Data has not yet been subject to quality assurance reviews.

a. Last Year's Accomplishments

This State Performance Measure was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. Based on the most recent data available from the BDARS, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the New Jersey Autism Registry is 4 years old. Although there is no time-line for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the Autism Spectrum Disorders because we link them to SCHS Case Management services.

While the causes of autism are not known, genetic and environmental factors are individually and in combination believed to have contributing roles. While there is no cure for autism, there are indications that a child's speech and cognitive development can be improved with early and intensive intervention. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention. In New Jersey, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the registry decreased from 4.4 years old in 2009 to 4.2 in 2010. We believe this is due to our work with the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program which increased the number of diagnostic evaluations conducted during the grant months. Unfortunately funding for these clinical centers ended in the early part of 2011, thus, potentially affecting the timeliness of new diagnostic evaluations as seen in the slight increase of age of first diagnosis in 2011.

In order for this performance measure to be accurately determined, patients with autism in New Jersey need to be reported to the Autism Registry by licensed health care providers. BDARS staff have conducted outreach to educate and inform physicians and health facilities about the registry, how they can register children with autism living in New Jersey, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development and developmental evaluations. Additionally they have trained staff from several private pediatric practices. These included the six grant recipients of the Governor's Council for Medical Research and Treatment of Autism's Clinical Enhancement Center Program, located across the state, nine Child Evaluation Centers, and several psychiatric/behavioral departments located within hospitals. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component to the BDARS. Staff continues to conduct mailings to facilities, providers, organizations, and stakeholders who diagnose or treat children with autism, and continue to send out mailings on a periodic basis to newly identified providers. Staff has also created materials for both providers and families about autism. These include an autism website and conference presentations and exhibits.

DHSS has also addressed this performance measure by creating the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program. Through grant funding, clinical centers have increased the number of diagnostic evaluations that they conducted and

have decreased their wait times for an evaluation, both factors that have the potential to impact age at first diagnosis. Additionally, several of the Centers provided outreach to primary care physicians to educate them about the red flags for autism and about the American Academy of Pediatrics' recommendation about screening for autism at specific well-child checks. NJ Pediatric Council on Research and Education (PCORE), through a subcontract with one of the funded Autism Clinical Enhancement Centers, has developed a curriculum to present at physician offices with the goal of increasing autism screening and therefore early identification and subsequent referral of those patients who are at risk of autism.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Audits of charts a yearly basis				X
2. Provider education				X
3. Annual Audits				X
4. # of families being offered services	X	X		

b. Current Activities

In 2011, over 2,600 children were newly reported to the Birth Defects and Autism Reporting System. This includes 381 registrations where the family chose to remain anonymous. Staff has stressed the importance of quickly reporting children diagnosed as having Autism by continuing to provide outreach about the Autism Registry through conference presentations and focused meetings. Staff participated in several exhibits including one at the New Jersey American Academy of Pediatrics and one at the Autism New Jersey annual conference and have presented to a number of private pediatric offices throughout New Jersey. Staff continue to send out mailings on a periodic basis to newly identified providers and have recently created the layout of a new Autism Registry webpage which will include information for parents, providers, and researchers. This new website will go live next month.

Providers with untimely reporting to the Registry were contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. Providers were educated as to their importance in the registration process and how faster registration enables children and families to more quickly obtain services through the SCHS Case Management Units. The electronic reporting component of the BDARS facilitated timelier reporting by facilities and since the BDARS added the SCHS Case Management Unit component, referral of these children to services is significantly faster.
DHSS is addressing this performance measure through the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program. The first round of grants came to a close this year, but Registry staff continue to work closely with the Centers so that awareness of the Registry and the importance of linking children with autism to services early is emphasized. Additionally, several of the Centers continue to provide outreach to primary care physicians to educate them about the red flags for autism and about the American Academy of Pediatrics' recommendation about screening for autism at specific well-child checks. NJ Pediatric Council on Research and Education (PCORE) continues to present their curriculum to local physician offices to further the goal of increasing autism screening so that early identification and subsequent referral of those patients who are at risk of autism is achieved.

c. Plan for the Coming Year

Staff will continue to focus on the importance of early identification of Autism. Outreach efforts will begin with harder to reach providers such as office-based pediatric offices and those not affiliated with a major hospital through mailings and collaboration with other state Departments such as the Department of Education and the Department of Human Services. Providers with less timely reporting to the Registry will continue to be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. The case management component of the BDARS will allow for an electronic assessment of referral rates. Registry staff will be able to use these reports to monitor timeliness as well as numbers. Quality Assurance visits to the sites of the six Governor's Council for

Medical Research and Treatment of Autism funded Autism Clinical Enhancement Centers as well Child Evaluation Centers and other hospital based providers will be developed and completed to verify reported information.

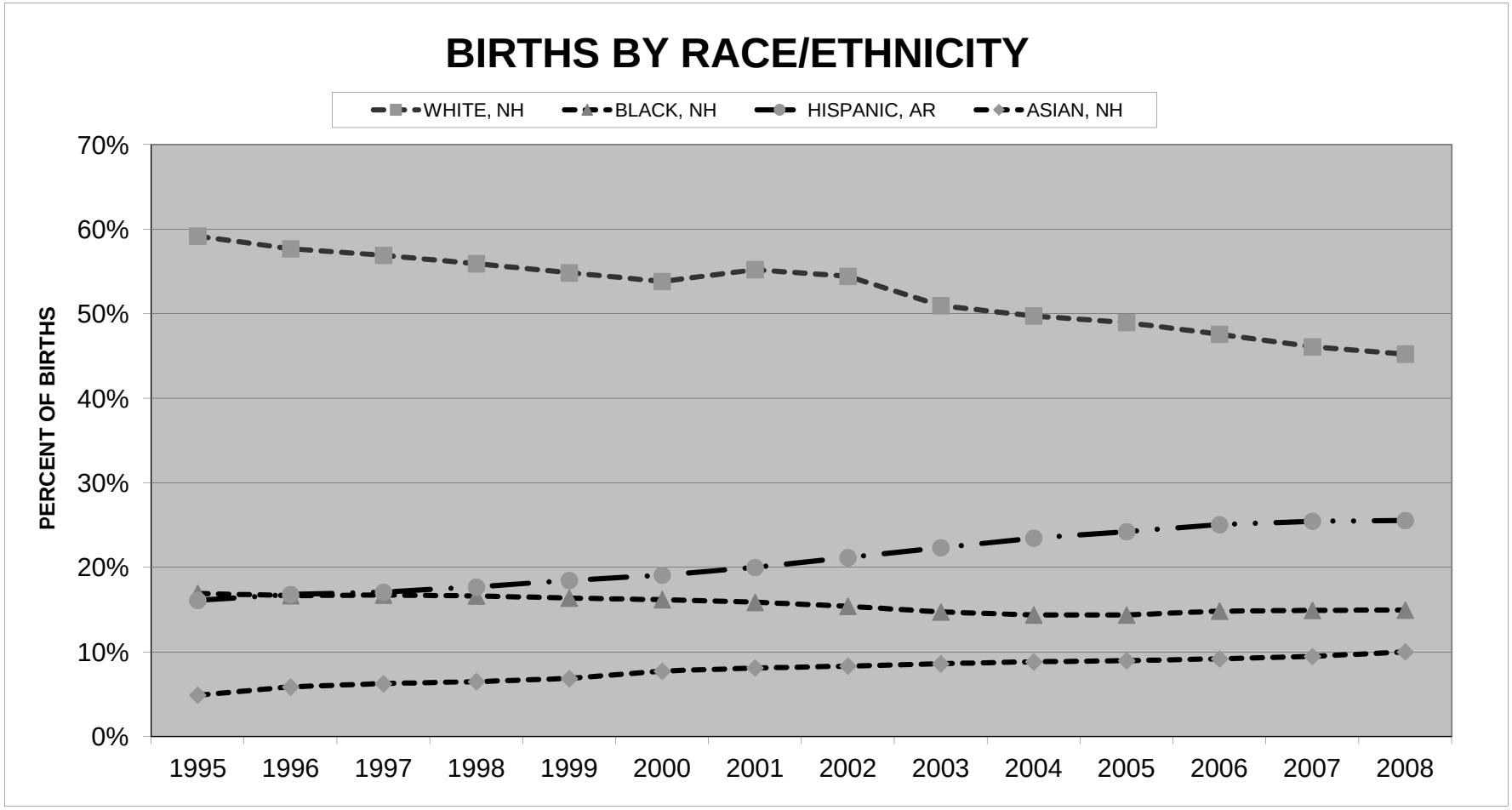
The Department of Health and Senior Services committed to continuing efforts to reduce the age of first diagnosis of autism. The Governor's Council for Medical Research and Treatment of Autism has posted a new RFA to create a Statewide Autism Center of Excellence that contributes to efforts to reduce the age at which children with an ASD are identified.

E. Health Status Indicators

State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance measures outlined above, Health Status Indicators are reported separately on the HSI Forms 20 to Forms 21.

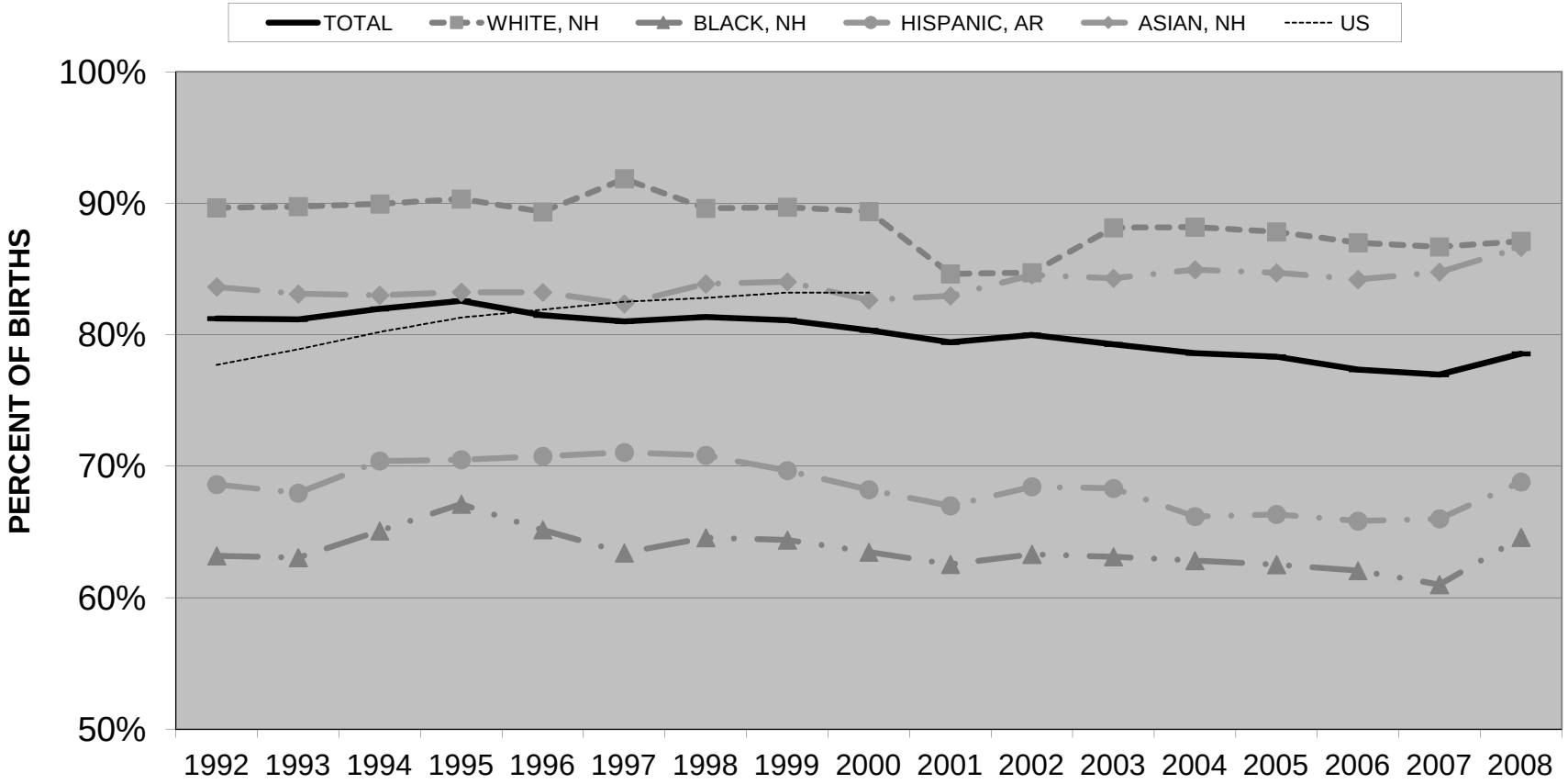
F. Other Program Activities

During FY 2011, the Family Health Line received and assisted 13,418 calls, and made 12,934 referrals. The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking. The Family Health Line employs three clinical staff members who are responsible to answer the Perinatal Mood Disorders Speak Up When You're Down calls. They screen the callers and coordinate working with Mental Health Providers.



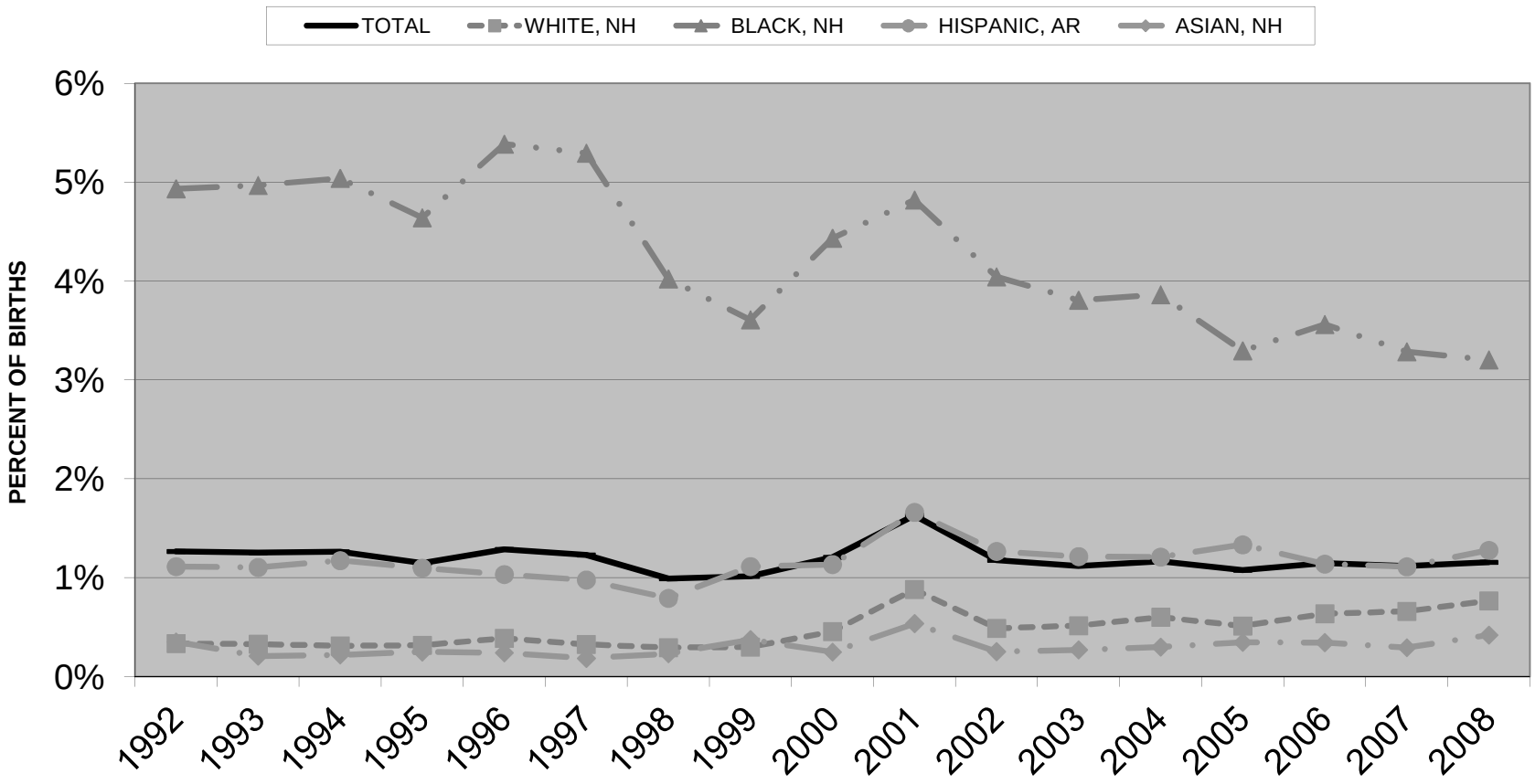
Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic; asian, Non-Hispanic

FIRST TRIMESTER PRENATAL CARE INITIATION*



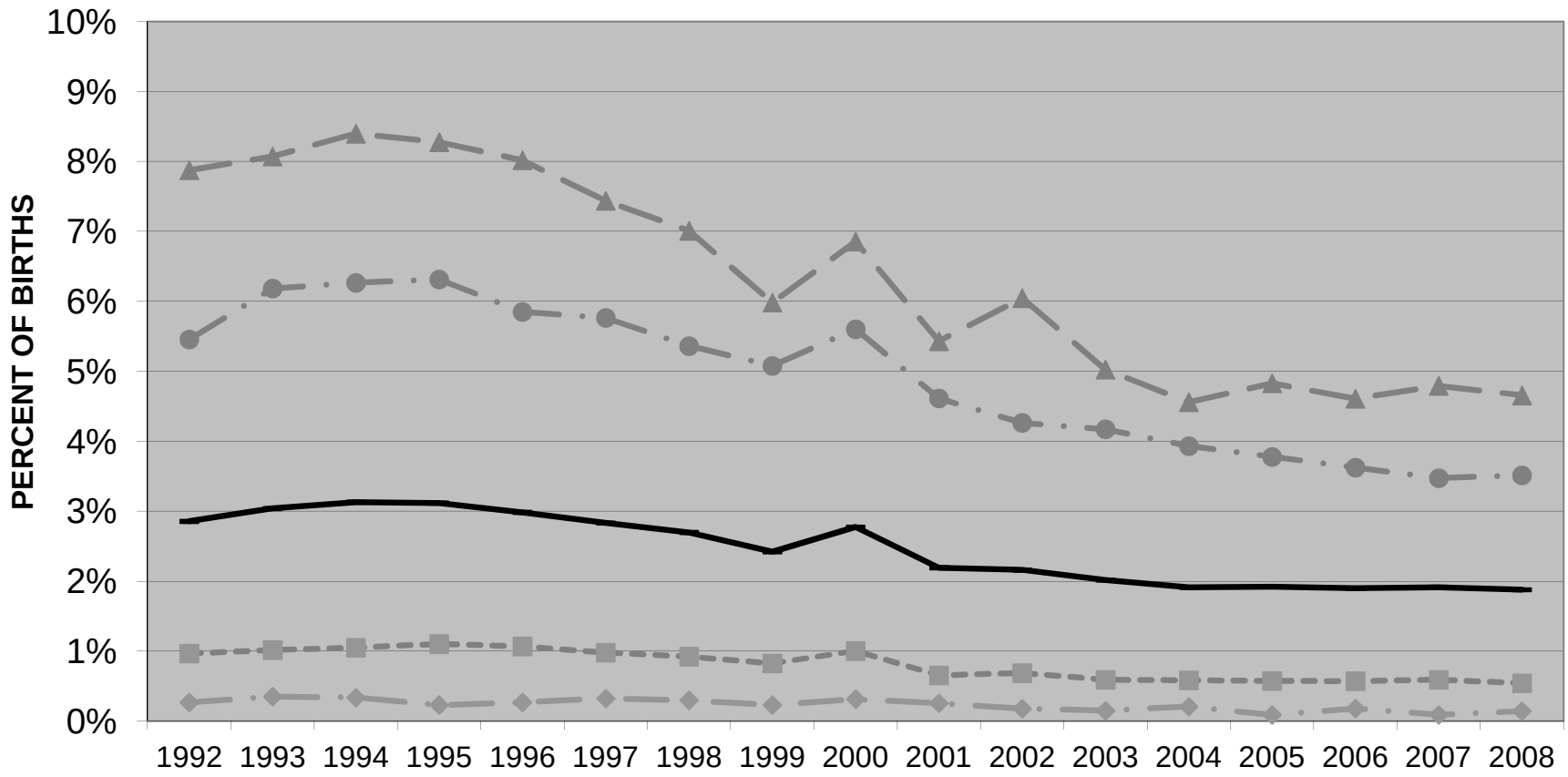
Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
*Initiation of prenatal care self-report as within first 13 weeks on BC. Missing and unknown responses excluded from calculations
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic

NO PRENATAL CARE UTILIZATION*

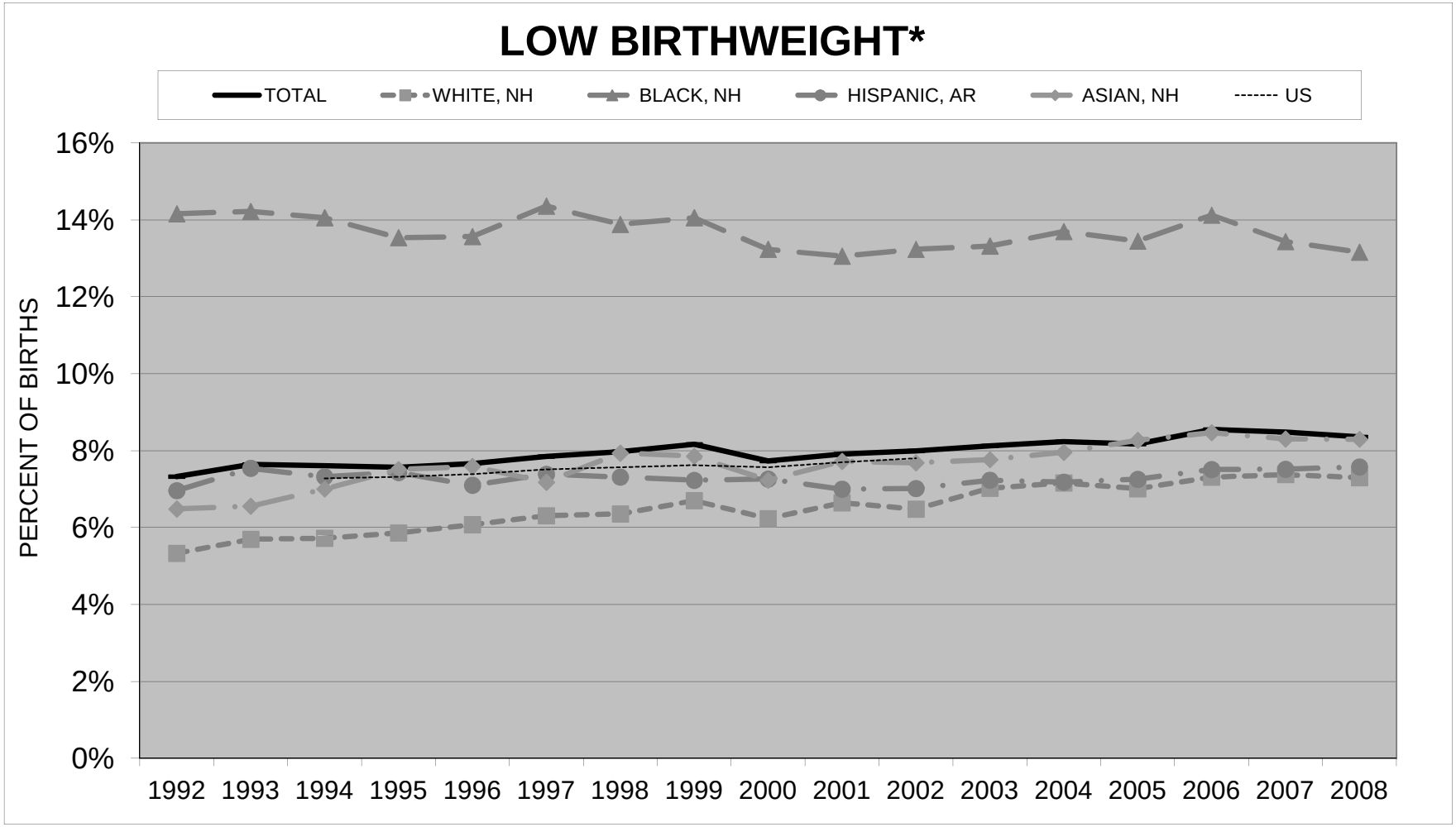


Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
*Source of prenatal care recorded as None. Missing and unknown responses excluded from calculations
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic

TEEN BIRTH (AGES 15-17)

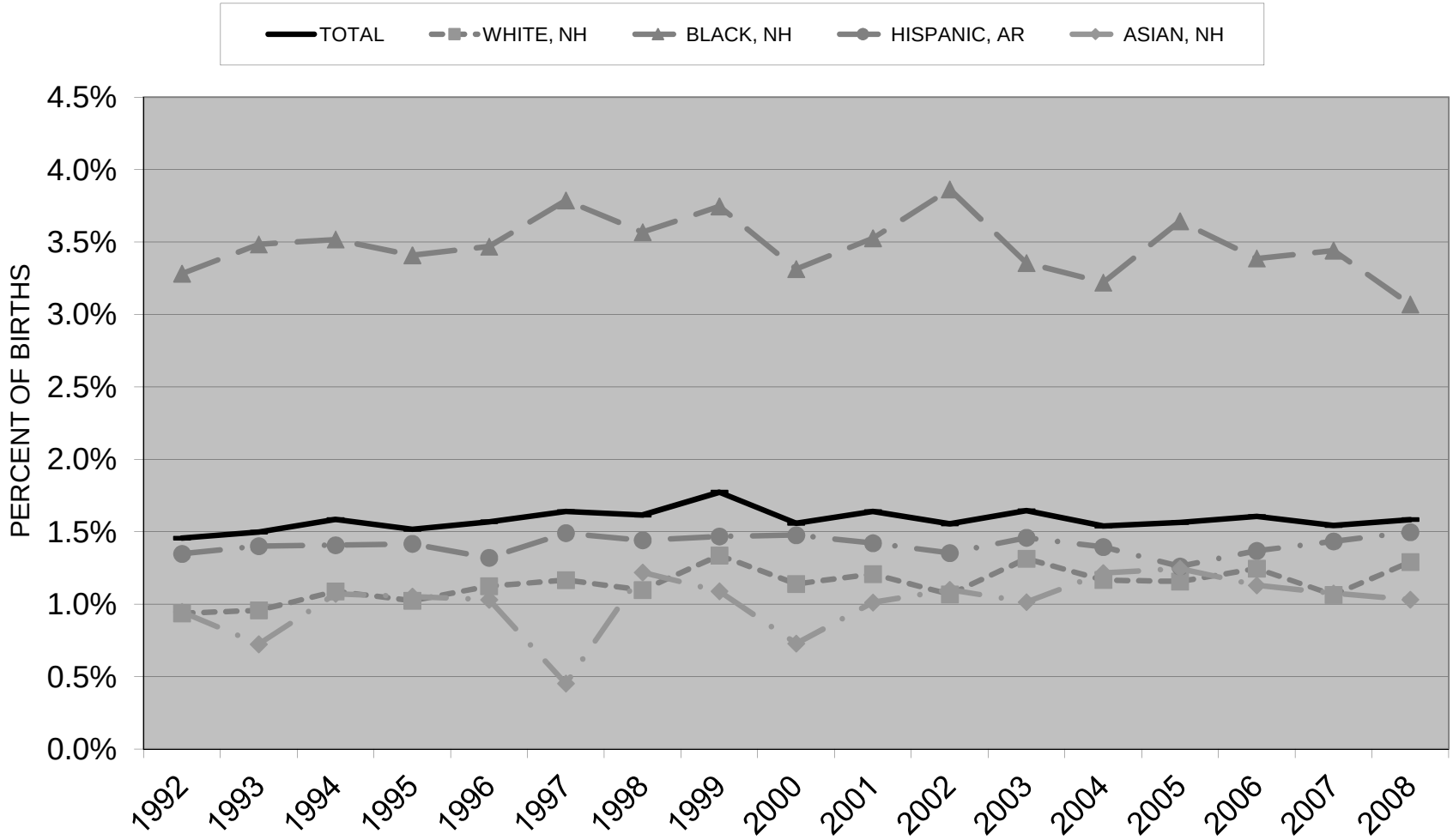


Source: NJDHSS Birth Certificate Files, as of 12//2009, New Jersey Residents.
*Live births to mothers 15-19 years old per 100 births.
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic

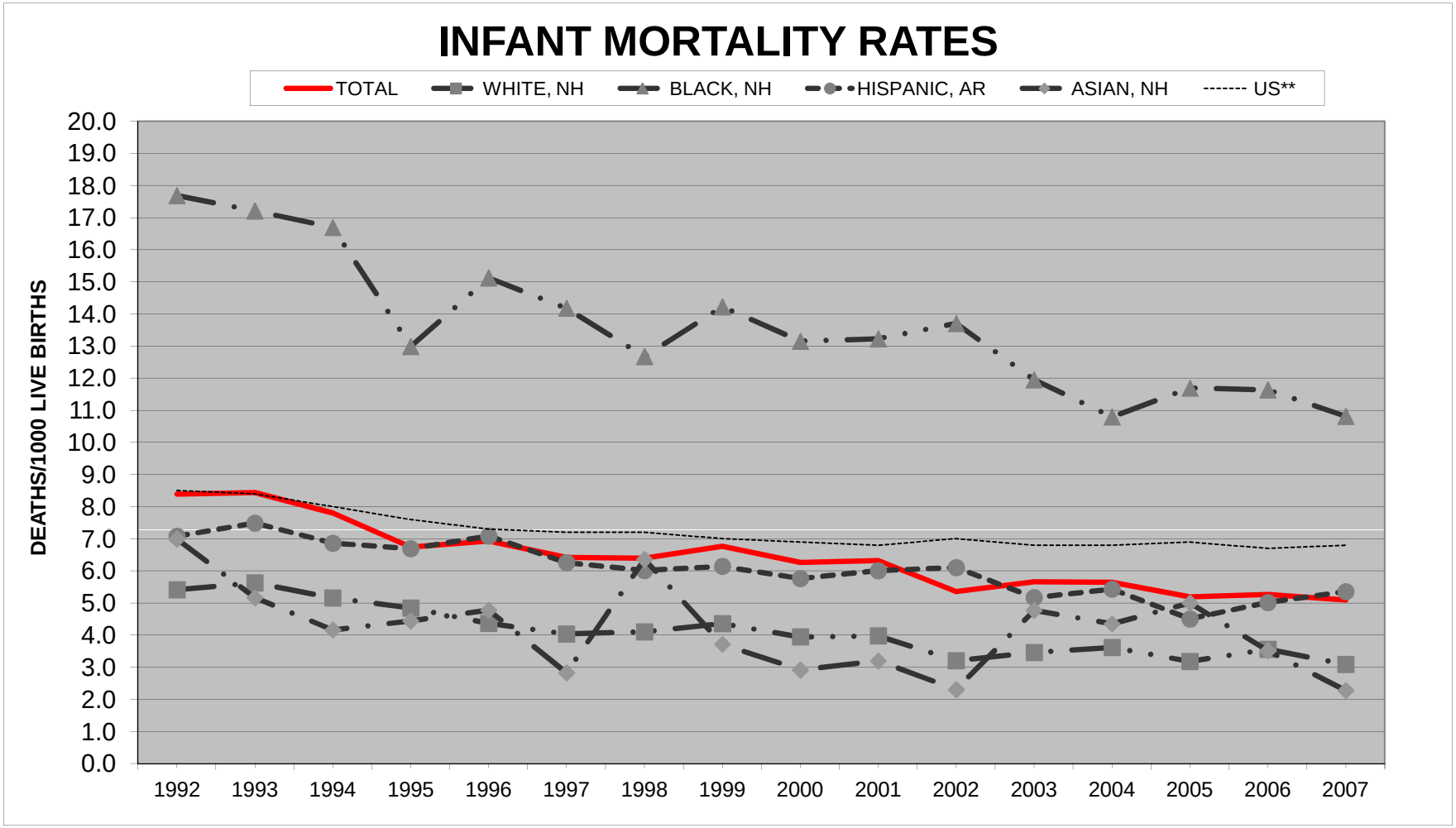


Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
*Low birthweight = birthweight <2500 grams.
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic

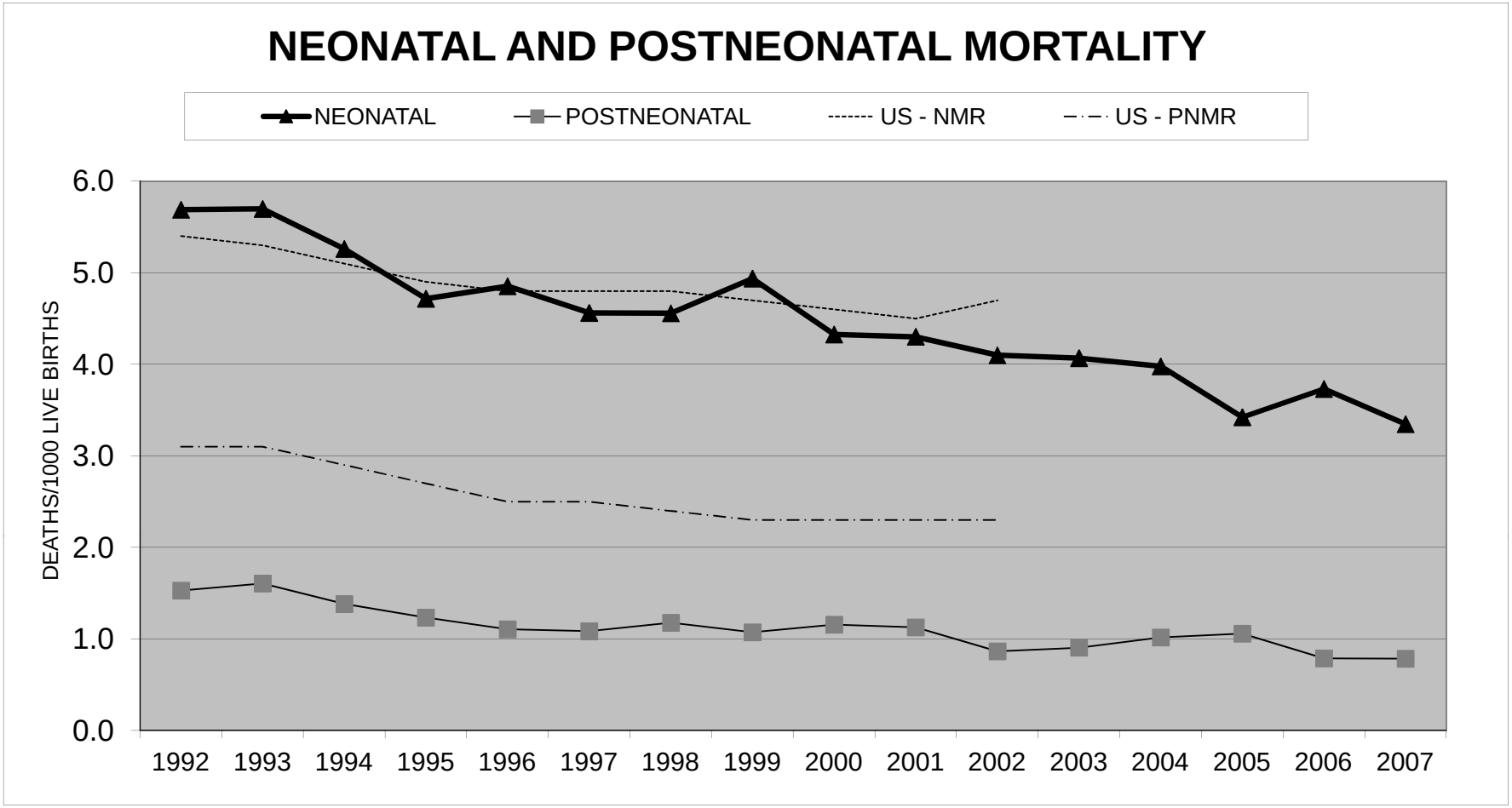
VERY LOW BIRTHWEIGHT*



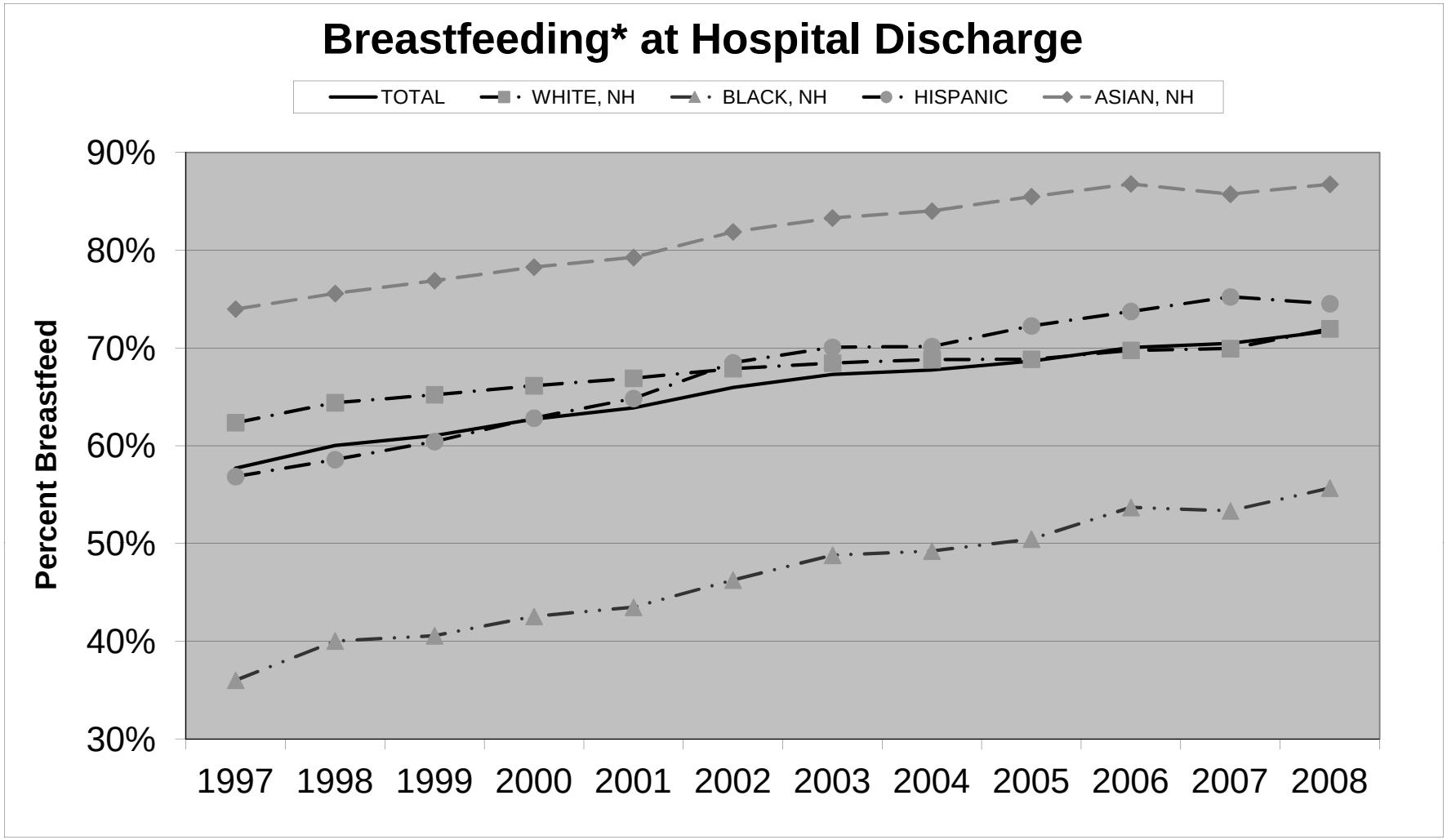
Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
*Low birthweight = birthweight <1500 grams.
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic



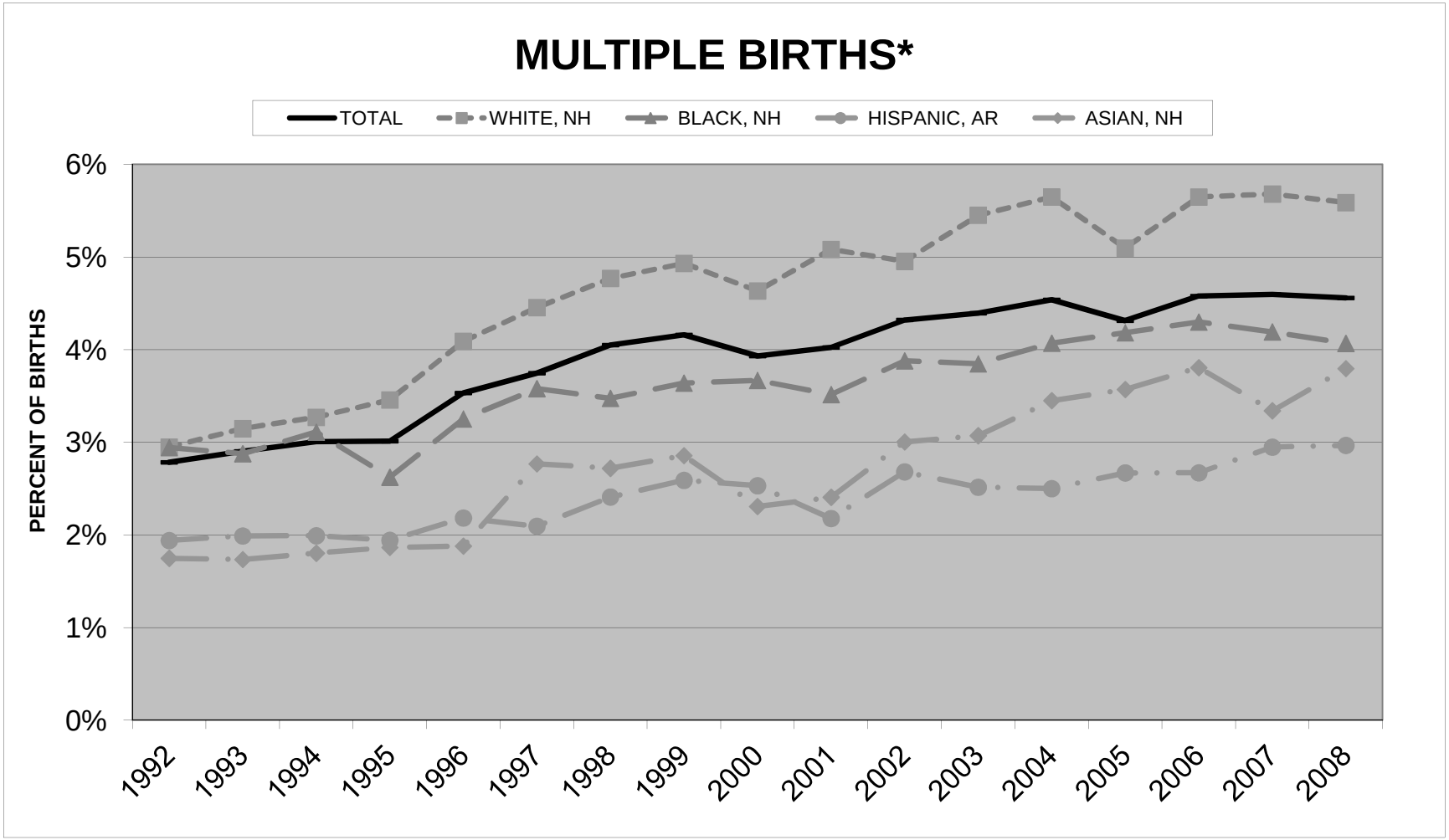
Source: NJDHSS Linked Birth Certificate Infant Death Certificate Files, as of 3/30/2012, New Jersey Residents.
Mortality rates = number of deaths in the age group in the calendar year * 1000 divided by the number of live births in the same year
Race/ethnic groups - Hispanic regardless of race; white, Non-Hispanic; black, Non-Hispanic, asian, Non-Hispanic



Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
Mortality rates = number of deaths from linked birth/infant death data set in the calendar year * 1000 divided by the number of live births in the same year
Neonatal deaths - occurring 0 - 27 days, Postneonatal deaths - occurring 28 - 364 days



Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
* Any breastfeeding in 24 hours prior to hospital discharge
Race/ethnic groups - hispanic regardless of race, white non-hispanic, black non-hispanic, asian non-hispanic



Source: NJDHSS Birth Certificate Files, as of 3/30/2012, New Jersey Residents. http://www4.state.nj.us/dhss-shad/home
*Birth order greater than 1
Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, non-Hispanic, asian, non-Hispanic